STACKS

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. January 1986, Vol. 73, No. 1



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JAN 29 1986
M. D.S.

PROFESSIONALS



The Florida Physicians Insurance uses selective, independent insurance agents to represent the Company. These professional agents are specialists in their field and are actively servicing our insureds. They will be happy to answer your many questions about the complex problems of medical professional liability. Phone one of our "Professionals" for the answer to your professional liability insurance program.

For more information, please contact:

FLORIDA PHYSICIANS INSURANCE

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

FMF IMPAIRED PHYSICIANS NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

January 1986 "Doctors Helping Doctors" Vol. 3 — No. 1

We're Getting. . . National Attention

The FMA-FMF's highly successful Impaired Physicians Program is attracting a great deal of national attention.

Medical Director Roger A. Goetz, M.D., and his wife, Kay Orr-Goetz, were guest speakers at a Seminar on Impairment presented by the American Veterinary Medical Association in Chicago, December 15-16. Dr. Goetz presented an "Overview of Impaired Professionals Programs" before an audience of some 135 veterinarians and guests.

Mrs. Goetz spoke on "Impairment — A Family Affair." The program also included H. Larry Gore, D.V.M., of Orlando, a member of the AMVA Committee on Impaired Veterinarians and the FMA-FMF Committee on Impaired Physicians.

Dr. Goetz and Dr. Gore also will be on the program for the American Medical Association's Seventh National Conference on the Impaired Physician in Chicago, April 10-13. They will participate in a discussion on mechanisms by which various health professions can work together in impaired professional programs. In Florida, a strong partnership between the FMA and the Florida Veterinary Medical Association has developed over the past three years.

Dr. Goetz also will speak to the AMA conference on the subjects of "Treatment Referral" and "What Works in Florida."

Advanced IP Intervention Workshop To Focus on Post-treatment Issues

The Committee on Impaired Physicians' Seventh Workshop on Intervention with Impaired Physicians will take the form of an advanced seminar focusing on post-treatment issues.

County medical societies, specialty groups and hospital medical staffs are encouraged to send representatives to the two-day program, which will be presented all day Saturday and Sunday, March 22-23, at the Diplomat West Hotel in Hollywood, Fla. Physicians who have been treated through the program also are strongly urged to attend, according to Roger A. Goetz, M.D., IPP Medical Director and Course Director.

There will be a segment on screening, with treatment personnel discussing the psychiatric, psychological, medical and family evaluations of troubled physicians.

"The turmoil throughout the community at the present time concerning the needs for adequate monitoring will be discussed," Dr. Goetz announced. "Biochemical monitoring issues will be presented along with discussions of the group processes of monitoring."

A segment on relapse will examine intervention in an individual who previously underwent treatment.

"Another presentation will involve the protocols used to determine and manage sexual problems in the physician," Dr. Goetz continued. "Often the stress of medical practice or other problems results in an acting out of a sexual nature."

Other topics will include:

- The neurologically impaired physician who suffers from early senility or decreased cerebral function.
- Legal aspects of impairment as stated in the Florida Medical Practice Act and other statutes.
- Intervention among families and family therapy.

A special added feature of this program will be a twelve-step meeting on Saturday evening.

When all speakers are confirmed, the complete program will be published in *FMA Today,* Dr. Goetz said.

Application has been made to the Florida Academy of Family Physicians and to the Florida Medical Foundation

(Continued on Next Page)

Pennsylvania Searching For Medical Director

The Pennsylvania Medical Society is continuing its search for a fulltime medical director to head up its Impaired Physicians Program.

Qualifications include: documented experience in the field of substance abuse; three years of documented sobriety and/or experience in a recovery program; administrative and managerial experience; good communications skills; reputation for integrity; excellent physical and mental health; and eligibility for licensure in Pennsylvania. Also, the medical director must be willing to relocate to Harrisburg, Pa.

Interested physicians should submit a letter of application, CV and salary requirements to: Pennsylvania Medical Society, c/o Abram M. Hostetter, M.D., Chairman, Impaired Physicians Program, 20 Erford Road, Lemoyne, Pa. 17043.

Standardized Aftercare Program Is Undertaken by Duval CMS

The Duval County Medical Society's Impaired Physicians Committee has developed a standardized aftercare program for physicians returning from treatment, according to Chairman Joseph H. Deatsch, M.D., and Guy T. Selander, M.D., Chairman of the FMA-FMF Committee on Impaired Physicians.

The program, similar to plans currently in use in Wisconsin and Georgia, will use the services of a professional facilitator, a trained chemical dependency counsellor experienced in working with health care professionals, IPP Medical Director Roger A. Goetz, M.D., said.

Duval County physicians returning home after treatment will be required to agree to participate in the group, which will provide therapy and monitoring. The program will include a weekly group therapy session followed by a 12-step meeting.

Alcoholism Is A Disease with Its Own Symptomatology

By LAURIN G. SMITH, M.D.
Member, Committee on
Impaired Physicians

What is alcoholism (alcohol dependence)?

It is a disease with its own symptomatology, and like for most diseases, effective treatment is available. It is a primary, chronic, progressive and, if not treated, a fatal disease.

Let's examine these descriptive terms. *Primary* means it is a disease unto itself and not just incidental to some other disease. *Chronic* means that it lasts forever; it can be controlled but not cured. *Progressive* means that without treatment it gets worse.

Although alcoholism has been established as a chronic, progressive and potentially fatal disease, it remains almost universally misunderstood. As early as 1958 the American Medical Association recognized alcoholism as a primary disease; yet, there are many even within the medical community who remain unconvinced.

Many treatment centers and treating physicians employ effective and proven therapeutic methods, but many physicians continue to rely on conventional psychotherapy or psycho-pharmacology (Valium, etc.) to treat alcoholism. Such methods tend to prolong the illness and enable the alcoholic to continue his drinking.

In no other disease is *denial* as strong as it is in alcoholism. Denial pervades virtually everyone associated with the alcoholic — the patient himself, his family, his physician, the insurance industry and society in general. Fortunately, however, the tide appears to be turning and more and more people are beoming aware of alcoholism as an illness.

The National Council on Alcoholism ranks alcoholism as the second most common disease in the U.S. (after cardiovascular disease) with approximately 10 million cases in 1980. It is estimated that one in 10 drinkers is an alcoholic.

How does one recognize an alcoholic? It is fair to say that if alcohol affects an individual's life in a continuing way, he has a problem with alcohol. That doesn't mean that everyone who drinks or becomes intoxicated on rare occasions is an alcoholic. But if such a pattern occurs and incidents occur often enough to cause physical, mental, marital, emotional, spiritual or legal distress, then the individual has a problem with alcohol.

Help is available. There are many good treatment programs in Florida, including those approved by the FMA-FMF Impaired Physicians Program. Some sufferers respond well to outpatient therapy, but inpatient treatment is indicated for many. In any event, the alcoholic must be willing to accept treatment if it is to be effective. He must surrender himself, cast denial aside and accept the fact that he has a potentially fatal disease. He must also admit that he cannot stop drinking by himself anymore than a diabetic can stop his diabetes by himself. Each has a disease that requires treatment.

Mixing Alcohol with Other Drugs Often Causes Bad Interactions

Mixing alcohol with other drugs often produces undesirable interactions. Arthur G. Lipman, Pharm. D., Professor of Clinical Pharmacology at the University of Utah, Salt Lake City, has prepared a chart lisitng the effects produced by ingestion of certain drugs combined with ethanol.

We are indebted to *Modern Medicine,* which published the complete chart in its November 1985 issue, for permission to reproduce the information over the next several issues of *FMF Impaired Physician Newsletter.*

Drug: Acetaminophen

Effect: Enhanced formation of toxic metabolites with chronic heavy drinking.

Comments: Chronic moderate to heavy drinkers who use acetaminophen should be monitored for hepatotoxicity.

References: Sato C, Lieber CS, J. Pharmacol Exp Ther 1981; 218:211.

Drug: Anticoagulants, oral

Effect: Increased anticoagulant effect in some patients; increased metabolism of warfarin in others.

Comments: Mechanism of potentiation is unknown; inhibition is due to induction of hepatic enzymes.

References: O'Reilly RA, Arch Intern Med 1981;141:458.

Drug: Antidepressants, tricyclic

Effect: Increased potentiation and decreased antidepressant effect have been reported.

Comments: Additive CNS depression may occur; large amounts of alcohol may potentiate antidepressant metabolism; caution patients about effects.

References: Dorian P et al Eur J Clin Pharmacol 1983; 25:325.

Drug: Antidiabetic agents

Effect: Alcohol may be hypoglycemic; sulfonylureas may cause an "Antabuse-type" reaction; chronic, heavy alcohol use may decrease sulfonylurea half-life; ethanol inhibits antidiuretic effect of chlorpropamide.

Comments: These are important interactions; patients should be cautioned to use alcohol in small amounts only, if at all.

References: Wardel EN, Richardson GO Br Med J 1971;3:309.

Advanced IP (Con't)

for AAFP Prescribed Credit and AMA Category I Credit.

The program will include group luncheons on Saturday and Sunday. The price for each luncheon will be $10, but there will be no other fees. Checks should be made payable to "Florida Medical Foundation."

Persons desiring overnight accommodations may call the Diplomat West at (305) 457-8111. Registrants should be sure to advise the reservation clerk that they will be attending the Workshop on Intervention with Impaired Physicians.

Registrations and requests for additional information should be directed to: Mr. Edward D. Hagan, Director of Medical Services, Florida Medical Foundation, P.O. Box 2411, Jacksonville, Fla. 32203, telephone (904) 356-1571.

Motrin® 800 mg TABLETS
ibuprofen



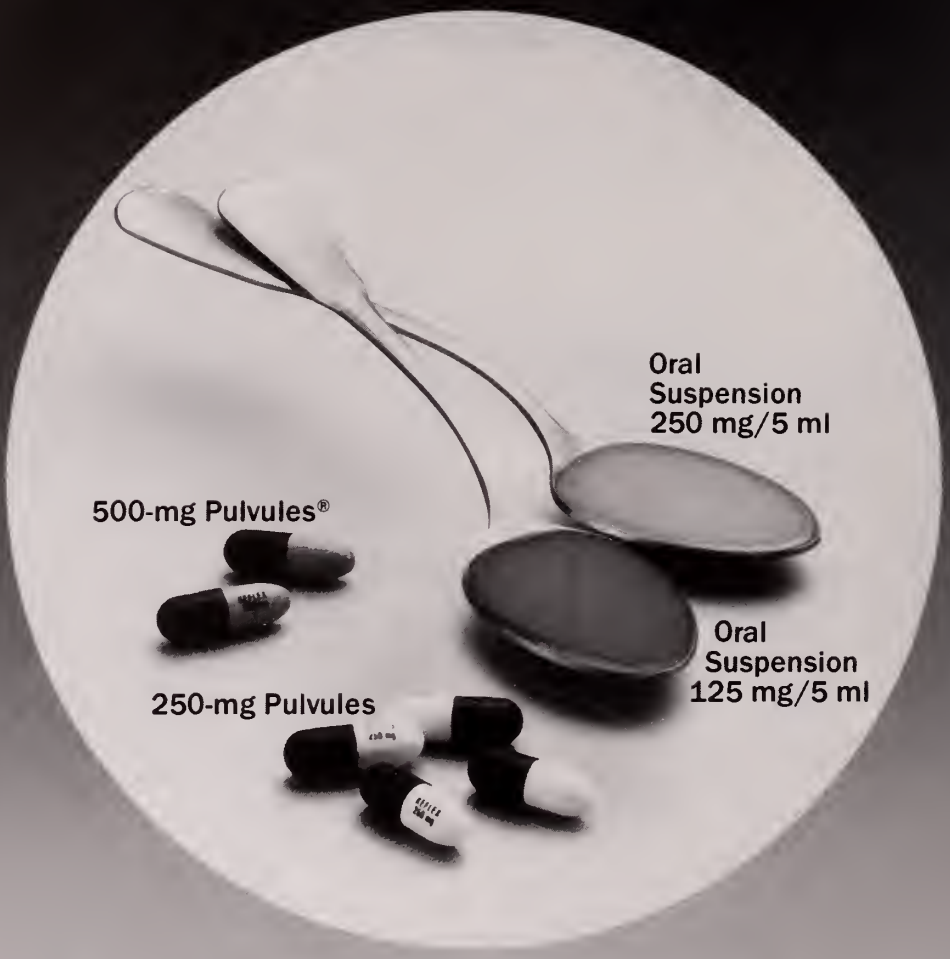
Extra strength
Convenience
Economy

Upjohn
A Century of Caring
1886·1986

©1986 The Upjohn Company

J-6138 January 1986

Easy To Take



Keflex®
cephalexin

Additional information available to the profession on request.

DISTA

420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

MASTER APPROACH TO CARDIOVASCULAR PROBLEMS

Fourteenth Annual Conference

The Contemporary Resort Hotel
Walt Disney World
Epcot Center
Lake Buena Vista, Florida
May 24, 25 & 26, 1986
MEMORIAL DAY WEEKEND

Guest Speakers:

Geoffrey O. Hartzler, M.D.
Present Status of Coronary Angioplasty

J. Willis Hurst, M.D.
What is a Cardiologist in 1986?

Nanette Kass Wenger, M.D.
State of the Art in Cardiac Rehabilitation

UNIVERSITY OF MIAMI FACULTY:

Agustin Castellanos, M.D.
Bernard J. Fogel, M.D.
Stephen M. Mallon, M.D.
Robert J. Myerburg, M.D.
J. Maxwell McKenzie, M.D.

For more information please call (305) 549-7124 or complete coupon and mail to: Y. Barcena, Cardiology (D-39), University of Miami School of Medicine, P.O. Box 016960, Miami, Florida 33101.

Please send me more information regarding "MASTER APPROACH TO CV PROBLEMS"

Name_____

Phone () _____

Address_____



The appearance of these tablets is a registered trademark of Wyeth Laboratories

DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper GI disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia, some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV) for (lorazepam) Anxiety

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

Wyeth Laboratories
Philadelphia, PA 19101

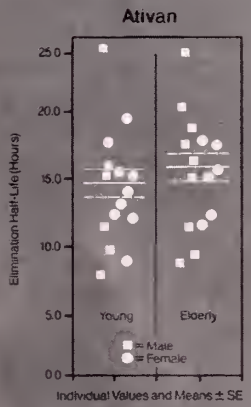
In addition to effective relief of anxiety associated with depressive symptoms...

Only Ativan® (lorazepam)C IV

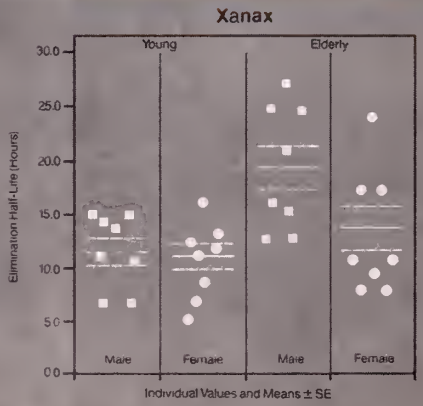
among leading benzodiazepines, has proof that its pharmacokinetics are not significantly altered by age.[1]

With Ativan, elimination half-life was very similar between young and elderly groups tested; differences did not approach statistical significance.[1]

Comparison of elimination half-lives in young and elderly subjects.



Ativan® (lorazepam)[2]
Ativan®, which is *conjugated* rather than oxidized, shows little difference in half-life (t ½) between young and elderly subjects.



Xanax® (alprazolam)[3] CIV
Xanax® requires *oxidative* (P450) metabolism; significant differences in half-life are shown between young and elderly male subjects; half-life is minimally influenced by age in women.

References:
1. Greenblatt DJ: Clinical study, pharmacokinetics and bioavailability in the elderly, Ativan® (lorazepam). Data on file. Wyeth Laboratories.
2. Greenblatt DJ, Allen MD, Locniskar A, et al: Lorazepam kinetics in the elderly. Clin Pharmacol Ther 26:103, 1979.
3. Greenblatt DJ, Divoll M, Abernethy DR, et al Alprazolam kinetics in the elderly. Arch Gen Psychiatry 40:287, 1983.

Wyeth Laboratories
Philadelphia, PA 19101

See important information on preceding page.

© 1985, Wyeth Laboratories.

THE PHYSICIAN'S ATVANTAGE

FUTURE transforms the IBM PC AT into a nine-user system to manage your practice.

Now FUTURE Information Systems offers the ATvantage that lets you practice medicine instead of accounting: Computone's powerful combination of Medical Office Management System software and AT expansion hardware. The total system that provides everything you need to automate your office from one of the country's fastest-growing computer dealers.

You can build a single IBM PC AT into a nine-user multi-tasking system with the AT ATvantage board, using any IBM PC, PCjr or inexpensive stand-alone terminals you may already own.



You can reduce paperwork with easy-to-use Medical Office Management System software, designed to let your staff enter or access information and simultaneously perform up to five related functions. Many accounting and management control operations are automatically updated with patient entry and posting.

And you can do it all with FUTURE beside you every step of the way, providing in-house or on-site training, complete hardware and software maintenance and continuous support.

Get the Physician's ATvantage working for you. Contact FUTURE Information Systems today.

Features of the Physician's ATvantage:

- ☐ Instant access to patient balance, insurance submission and insurance payment information
- ☐ Open-item patient accounting
- ☐ Patient statements and "Super-bill"
- ☐ Third-party insurance processing
- ☐ Patient/guarantor relationships
- ☐ Insurance rebilling or write-off
- ☐ Cash flow control
- ☐ Patient history
- ☐ Problem accounts
- ☐ Accounts receivable reductions of 20-50%
- ☐ Patient referrals
- ☐ Appointment scheduling
- ☐ Automatic audit trails
- ☐ Single doctor office, or several
- ☐ Multi-office practices

FUTURE℠ INFORMATION SYSTEMS
A Computone company

MOVING YOU UP IN THE WORLD℠

Pensacola: Cordova Square, 400 Bayou Blvd., Suite 49 • (904) 474-9855
Ft. Walton Beach: 514A Mary Esther Cutoff • (904) 244-8675
Other computer showrooms in a growing number of U.S. cities.

IBM PC, IBM PCjr and IBM PC AT are trademarks of International Business Machines Corp. ATvantage is a trademark of Computone Systems Inc.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JANUARY 1986, Vol. 73, No. 1

CONTENTS

SCIENTIFIC ARTICLES

Keith W. Chandler, M.D., Allan L. Goldman, M.D., and Richard G. Connar, M.D. **25** Laser therapy of primary lung cancer

Richard Howard, M.D., Ph.D., Bruce Brennaman, M.D., and Spencer Lieb, M.P.H. **29** Soft tissue infections in Florida due to marine Vibrio bacteria

David W. Cahill, M.D. Ernesto Botero, M.D. and Walker L. Robinson, M.D. **35** Neurosarcoidosis presenting as an intracranial mass

SPECIAL ARTICLE

Richard J. Feinstein, M.D. **43** When should the sick doctor stop caring for patients, and who will make that decision?

COVER

This month's cover of *The Journal* is a drawing by Jacksonville artist Tom Phillips in celebration of the past and forthcoming years.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.*, [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Forida Medical Association, Inc.

DEPARTMENTS

9 President's Page
FMA: working to ensure future success for Florida Physicians Insurance Reciprocal

11 Editorials
Life is not a spectator sport
Clyde M. Collins, M.D.
The liability crisis: 1986 and beyond
Lee A. Fischer, M.D.
Physicians' "rebates" — incentive or bribery?
H. Frank Farmer Jr., M.D., Ph.D.
Let us stand together
Henry L. Harrell Jr., M.D.

19 Letters & Viewpoints

47 Medical Economics
Marketing of medical services
Jacques R. Caldwell, M.D.

53 Notes & News

54 Deans Message

54 Encores!

61 Scam of the Month

65 FMA Auxiliary
AMA-ERF supports quality medical education and health care
Mrs. Randall deB. (Sue) Bertolette

68 Meetings

72 Classified Advertising

78 Index to Advertisers

78 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D.

Medical Economics Editor
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting
Editorial Staff:
Karl Altenberger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.

PHYSICIANS, A WEEKEND WITH THE RESERVE ISN'T JUST ANOTHER DAY AT THE OFFICE.



It's not just different in the Army Reserve, there are opportunities to explore other phases of medicine, to add knowledge, and to develop important administrative skills. There are enough different needs to fill right in your local Army Reserve unit to make a weekend a month exciting and rewarding.

Explore the possibilities. Call our officer counselor:

(North Florida)
CPT WINOKUR, MSC
(305) 896-4930/4793 COLLECT
USAR AMEDD PROCUREMENT
3101 MAGUIRE BLVD., SUITE 166
ORLANDO, FL 32803

(South Florida)
CPT WALTER DAVIS, MSC
(305) 667-5600/5609
USAR AMEDD PROCUREMENT
SUITE 207, 5900 S.W. 73RD STREET
MIAMI, FL 33143

ARMY RESERVE. BE ALL YOU CAN BE.

FMA: working to ensure future success for Florida Physicians Insurance Reciprocal



In writing this presidential page at the beginning of this new year, we cannot avoid thinking about one year ago when we were successful in rescuing the Florida Physicians Insurance Reciprocal out of receivership. This brought some peace of mind to thousands of physicians in the state who were on the verge of finding themselves without continuing professional liability protection and no prior acts coverage.

The leadership of the FMA has been directly involved in the development of the new FPIR and a number of your officers and FMA Board members serve as members of the FPIR advisory board. As such, we have been very careful in the establishment of the company in an effort to provide long-term guarantees for all the insureds.

It has been a long, hard year. At the beginning it was all new to us because our knowledge of the insurance business was very limited. Through lectures, perseverance and study we have acquired a broader knowledge and more realistic understanding of how the insurance business works. We have benefited greatly from the experience and excellent management that have been provided by Mr. Dave Rader and other members of the Professional Insurance Company of Ohio (PICO) which serves as the management company for the FPIR. This experience has been very valuable when applying the knowledge we have gained to the medical malpractice problem and its relationship with insurance rates.

Being inside the company, accepting the responsibility of endorsing it in the name of FMA and raising questions at all meetings about all the transactions, including investments and operations in general, help to guarantee that the FMA membership will be protected at all times and in the future.

This year a new and novel concept for the Reciprocal is being implemented. The FPIR is being converted to a stock company; therefore, all members of the Reciprocal will be stockholders. This has multiple benefits; one, when the company realizes profits, these profits may be distributed as dividends to all policyholders. Two, in order for the company to survive in this volatile environment all the members must exercise every caution to minimize risks in their practices. At the same time this will give impetus to the FMA's efforts to achieve legislative changes in the tort system or in seeking alternative solutions that will help to ameliorate the liability crisis. This will create benefits for all the physicians and their patients.

We have all witnessed or been directly affected by insurance companies leaving the state or declaring insolvency and dispersing in the past, leaving a number of physicians in very difficult situations. Our presence on the advisory board of the Reciprocal helps guarantee that measures will be taken well ahead of time to ensure that our insurance company remains solvent at all times.

You all know that St. Paul Fire and Marine Insurance Company has informed its agents that no new physicians will be insured in 1986 except in special circumstances which are very limited. This creates a problem for new physicians coming into

practice by limiting the options. We must be able to keep our doors open for this group of doctors every year and give them all the possible facilities to have the insurance they need.

On the other hand, FMA is actively working on eliminating mandatory insurance requirement as a condition of licensure because it is inherently wrong, discriminatory and unfair. It poses a serious problem for semi-retired physicians with no hospital privileges and part-time physicians who cannot afford to pay the premiums while their exposure is minimal, if any. These physicians will have to relinquish their licenses and close their doors. The citizens of the state cannot afford to lose these practicing physicians, most of them being either experienced doctors or early in their career.

A strong, well-managed, conservative physicians owned insurance company such as the FPIR is a must in our state. If we did not have one, we would be working diligently to create it, because the physicians of Florida need the peace of mind of knowing that in these precarious, litigious times insurance will be available to all of them. We all have to work to preserve it.



Life is not a spectator sport

"He has existed only, not lived, who lacks wisdom in old age."

Looking forward into an empty new year strikes one with a certain awe, for one finds therein nothing recognizable. The years behind have a friendly aspect, being warmed by kindled fires, echoing with the sounds of our own voices, and the flesh endures the storms of the present while the mind those of the past and the future as well.

Looking back in retrospect on the old year, one's duty was not always clear nor was one's work well defined. Theories failed and life was hard to handle. What actually was the purpose of one's life? If the purpose is to live and create, what must I do, this year, to give meaning and my own values to my life? For life is a perpetual compromise between the ideal and the possible.

It is not one's faults that ruin a person, so much as the manner of conduct after the fault has been committed. The wise profit by the suffering caused by the act and forget it, gaining a ripening influence rather than growing narrower and bitterer. The chief cause of misery is less the violence of one's passions rather than the feebleness of one's virtue.

Letting go of pretense, worry, discontent and self-seeking, and taking hold of time, work, happiness, love, duty, friendship, sorrow and faith, let me so live as to be an inspiration, strength and blessing to those whose lives are touched by me.

Speeding toward the 21st century on a global space craft which has sustained billions of human passengers for more than 2,000,000 years as it orbited around the solar system, let me view the world as the astronauts saw it, a fragile but sturdy sphere. Instead of seeing the world in terms of racial divisions and national territories or ancient rivalries and provincial fears, implant in me the attitude and action that treats each citizen of the earth as fellow crew members of a global spaceship.

In growing older, it is easy to let life slip by, making compromises with the future and with one's self. As the years crowd in, tomorrow seems less glamorous and one's soul is in constant danger of growing sleek and overly satisfied. In this new year may I not lose the joyous excitement and blessed thrill of ambition. Not so much for worldly things, money, fame or applause of the crowd, but the ambition to be busy, to be a part of the hurrying active world and so read progress and delight in every task. May I not lose the desire to see beauty and as far as it is in my power, create it.

A mature society develops an effective balance between the old and the new. The mature individual does the same thing. He reveres the past for the truths it brings to the present and honors the present for the new truths that are revealed but gives blind allegiance to neither the old nor the new. His loyalty is dedicated to that which is true be it old or new.

The new year offers time and energy to study, especially the humanities, to expand the imagination, enlarge the personality and enable one to become something different and better. For without this, future generations of technical barbarians will do brilliantly what they have been taught to do, but will be blind to the consequences of their actions. The greater need in each new year is not so much for better trained technicians as it is for more well-rounded, compassionate persons of integrity.

My prayer for the new year is a dream that in spite of daily headlines prophesying man's destruction, a better world can be built, a world of peace and human brotherhood. Perhaps not in my lifetime, but in my small way I want to have a share in

making it come about. In the new year I will try to keep the heart unwrinkled, to be hopeful, kindly, cheerful, reverent and so I may perform at my best and accomplish what I can.

Clyde M. Collins, M.D.
Consulting Editor
Jacksonville

The liability crisis: 1986 and beyond

Five years from now 1985 will be remembered as the turning point in the struggle to solve the liability crisis that haunts every physician and threatens to destroy the American health care system. The Amendment 9 debacle and the reform legislation passed in 1985 began the process of solving the problem by bringing the crisis to the public's attention. Our actions forced the Florida legislature to enact legislation in 1985, and I predict more action will be taken in the next two years as medicine is swept up in society's rush to solve the liability problem that is affecting every aspect of our lives.

Two years ago physicians stood alone complaining bitterly about a "malpractice crisis" that was costing doctors and patients billions of dollars and threatening the quality and even the availability of medical care. The trial attorneys responded by saying that malpractice was really caused by bad doctors and that we were only trying to help ourselves by inventing a crisis. The press, never our allies to begin with, depicted the problem as a squabble between two powerful and wealthy groups who were both somewhat right and both somewhat wrong. Surveys revealed that the public was generally on our side, but really could not get too worked up about the problem. After all, patients could still get medical care and were generally insulated from exorbitant medical costs by insurance companies. Physicians were an isolated voice whose message fell on deaf ears.

As we begin 1986 all that is changing rapidly. The press has discovered that there is indeed a nationwide liability crisis of tremendous proportions, medical malpractice being only one element. Cities are finding themselves uninsurable or insurable at exorbitant rates. Businesses are finding the same thing. No one is immune to a lawsuit, frivolous or otherwise. The threat of litigation, real or imagined, coupled with the unavailability of insurance and astronomical premiums, is creating a major crisis in this country. To physicians this sounds ironically familiar. The public is finally demanding action, and reform when it comes will include us. We move a little closer to a solution with each abusive lawsuit dutifully reported by the media.

- A roller rink is forced to close citing its inability to afford astronomical insurance premiums because everyone who falls, sues.
- The wife of a man killed by terrorists on a hijacked cruise ship sues, among others, her travel agency.
- A woman sues a soft drink company for "pain and suffering" after discovering a bug in her soft drink can.
- An attorney files a malpractice suit, takes it to court without an expert witness, and after a week-long trial the doctor is acquitted by a jury in 20 minutes.
- A Christmas boat parade is almost cancelled because the sponsoring group is unable to obtain insurance.

Americans only respond to crisis, and the best way to get action is when the crisis hits each individual in his wallet. The public is finally beginning to suffer and will not stand for the shenanigans much longer. When people ask physicians how we think the problem should be solved, we can graciously offer our help. I would like to see the following take place in order to solve the liability crisis.

- Mandatory review of all attorneys who file and later drop or lose a malpractice case. This will dramatically cut down on the number of frivolous lawsuits filed by untrained, unscrupulous lawyers out to make money by forcing a settlement on cases that have no merit or "rolling the dice" for that jumbo, once-in-a-life-time award. Physicians are reviewed by committees when they "lose" a patient and must answer to their peers. The 1985 malpractice law required a review of doctors if they are involved in a certain number of suits so I see nothing wrong with reviewing lawyers' performance and disciplining those who file frivolous lawsuits. The consumer movement taught us to get as much information as possible. Should not the public know that the attorney they picked has filed numerous cases and lost most of them?
- The Florida Medical Association should compile a list of all lawsuits filed in Florida and their disposition. FMA should actively publicize the

frivolous ones (and we all know there are alot of them) to counter the few brain-damaged baby suits that the trial attorneys love to parade in front of the public. Except for anecdotes such as the case noted above, no one has any hard data on just how many ridiculous suits are filed. If the public and the legislature knew the facts, it would help our cause.

- Society is going to demand a cap on general damages. Families should not become instant millionaires because of some emotional judgement call.

- The doctrine of joint and several liability should be abolished.

- Attorney's fees must be limited. There is no justification for attorneys to receive 40-50% of an award that the jury gives to an injured plaintiff. Certainly, good representation is expensive, but so is good medical care. If attorneys are not satisfied with getting paid for services rendered instead of the present Las Vegas style system, maybe they should change professions.

- Attorneys readily admit that only the very wealthy could afford a lawyer if it were not for the contingency fee system which they claim is the poor man's ticket to the courthouse. To my way of thinking there is something basically wrong with a system that 98% of the public cannot afford, but that is a different subject. The contingency fee system should be replaced by a fund to pay awards to plaintiffs and attorneys' fees similar to a workers' compensation program. The money for such a fund could come from a "tax" placed on medical service rendered throughout the state. A few years ago I suggested a Professional Liability Adjustment Fee (P.L.A.F.) that could be added to each bill coupled with a public education campaign telling our patients exactly why they were being forced to pay it. PLAF's time may have arrived.

For the time being individual physicians and their representative organizations must continue to press for change. We need to be vocal and, yes, militant. We must not give up in our attempt to correct an unfair system that threatens to destroy the finest health care system in the world. Our present patients and those we will serve in the future deserve the best.

Lee A. Fischer, M.D.
Associate Editor
West Palm Beach

Physicians' "rebates" — incentive or bribery?

Recently, the media have informed us that several hospitals across the country are offering "incentives" in the form of cash payments to physicians when a patient is treated for less than the DRG reimbursement. If the services amount to less than the preset limit, the hospital will make a profit, at least on that admission. The physician who cares for the patient will share in the monetary gains under the proposed scheme. Of course, at this point in the evolution of medical care, all physicians have become familiar with this type of approach. The federal government inaugurated this scheme in October 1983 with the advent of DRGs. The objective is to reward the hospital for efficiency in treating patients and discharging them in a timely fashion. The planners knew that the hospitals would lose on some of these patients, win on other patients, but since the number of DRGs was over 450, things would average out and the hospitals would not be punished for a few bad cases of DRGs. It was up to the hospitals and medical staffs to police their ranks to insure the survival of their institutions. As results are still being evaluated, and while there is much talk that inappropriate discharges and poor medical practices have evolved, it is very difficult to show that patients have been harmed because of DRGs. The plan has saved millions of dollars and it appears thus far that the good points appear to outweigh the bad.

The proponents of the plan to give cash rebates to physicians who are able to treat and discharge patients below pre-determined outlays of money point to Washington, D.C. as justification for this idea. If the federal government can implement this type of plan and reward hospitals for being efficient, why can hospitals not similarly reward physicians for their diligent efforts? The proponents point to many examples in our society which reward workers on the basis of productivity or efficiency: the saleman working on a commission, the factory worker getting paid on a production basis, or the professional athlete being paid on points scored. Is it not the American way to be awarded for performance?

The arugment for the rebate system can be persuasive on the surface. However, scratch the surface and the tarnish begins to appear. It is very easy to be lulled by the arguments that these incentives have become a part of our life — and a very important part. This is absolutely true and American society has always awarded efficiency and productivity as valued traits of its people. However, the cash rebates proposed by the hospitals are not for efficiency or productivity. It is a reward for doing what is right. Regardless of what the hospitals say or what rhetoric

the proposal is disguised in, that is exactly what it is. Throughout the history of medical ethics, medical practice has been based on treating the patient with appropriate medicines and advice. The medical profession has always condemned anything that does not follow these guidelines. Accordingly, superflous tests or procedures done for the economic reward of the hospital or physician have been thought to be unethical and in most states illegal. If a patient is treated appropriately and adequately, that patient is going to be discharged from the hospital when he has received that treatment. If a patient is staying longer than necessary, then the physician is either not treating the patient adequately or extending the length of care for economic reasons. Either reason is viewed with disdain by most physicians.

If the above statements are correct, and I believe they are, then to give a cash rebate to a person for discharging a patient appropriately is to reward him for doing the right thing, or conversely for not doing the wrong thing. If, on the other hand, a physician keeps a patient in the hospital longer than necessary, must he not be subject to disciplinary action? On most hospital staffs he would most certainly be disciplined. Let us not be misled that the cash rebate plan is the American way and that efficiency should be rewarded in a pecuniary manner. It is a negative approach that is foreign and repugnant to American society and certainly does violence to the history of medical ethics in this country. Arguments pour from many corners that those who oppose this approach are behind the times and unwilling to face the "new medicine" or to change with the times. Ridiculous. There is nothing in the changing medical mores of this country that should justify a system which financially rewards a physician for doing the right thing. It is easy to divorce medicine and physicians from the rest of American society and to say that we operate on a different scale and with implied higher values. But there is danger in this as organized medicine in America has often been accused of standing apart from American society and away from the mainstream. This has partly been true in the past although there is nothing out of the mainstream in rejecting the rebate idea. Our society does not usually offer rewards on a negative basis or encourage people to avoid the wrong things by paying them. This is as out of the mainstream of American thought as you can get.

The medical profession owes to itself and the public which it serves to stop unnecessary hospital stays by internal monitoring such as utilization review and quality assurance. This is exactly what we are doing as the review process within medical staffs appears to have intensified over the past several years and now is working to reduce unnecessary admissions and prolonged hospitalizations. This process of correcting deficiencies by counselling, and if necessary by disciplinary actions, is the way the rest of the society works and the way the medical profession should work.

No, scrape away the thin surface covering and the rebate proposal is revealed for what it is. It is an attempt by hospitals to fill their beds by offering to reward doctors for not practicing poor medicine. I wonder what the response of the participating physicians would be to the hospitals' invitation to admit their patients to the rebating hospitals if those hospitals promised that prolonged hospitalizations would be solved by strict review and the physicians rewarded by being able to practice in a hospital that prides itself on reducing unnecessary hospitalization by strict review and internal audits. The reward for the physicians would be to practice in hospitals that provide this type of service to their patients. How many of the participating physicians would find this as an important enough reason to admit their patients to these hospitals? I doubt that many physicians would switch their allegiance from other hospitals, and therein lies the crux of the problem. If the doctors who participate in this scheme cannot see that the rebates are alien to the history of medical care and ethics in this country and indeed to American culture, then we may be in for some very difficult times ahead.

These rebates may indeed turn out to be legal as they are now being tested in courts, but we ought to remember that what is legal is not necessarily moral or ethical.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor
New Smyrna Beach

Let us stand together

It is time we all grew up. As the medical malpractice crisis has become increasingly severe, the various groups invovled seem to have become increasingly polarized. The lawyers say the problem is all caused by bad doctors; the State Insurance Commissioner says it is caused by insurance companies making too much profit; the insurance companies blame it on the avarice of the state's lawyers; and we doctors tend to blame everyone else — lawyers, state government, and insurance companies. It does not take much calm evaluation of the situation to reach the obvious answer that this is a complex problem with no simple explanation. The tendency to point fingers and call names on all sides is not only counterproductive, it is wrong. It is difficult for us, as physicians, to see the problems from the viewpoint of others, but it would surely be worthwhile to try.

There is an increasing climate of distrust between doctors and lawyers these days. This distrust is surprising when you consider that the members of the two professions generally live in the same social and economic strata of our society. We live next to one another, go to the same churches, have our children in the same schools, play golf or tennis together — a few of us could not truthfully make the old joke that "some of my best friends are lawyers/doctors." Many of our families are made up of members of both professions. Why then do we so often hear members of both professions making sweeping charges of immorality and corruption against each other?

Part of the problem appears to be a basic difference in how the professions define morality. The legal profession is concerned with the smooth operation of society as a whole and therefore bases its definition of morality on the general rather than the individual perspective. It is morally acceptable to represent a guilty client because it would be immoral for our society to deny anyone the right to representation. Medicine on the other hand is concerned primarily with the individual. It is morally acceptable to use public funds to perform heart transplants on individuals who need them even though our social welfare system would be bankrupted by an attempt to make such procedures readily available to all. Thus we judge right and wrong from a different perspective. Lawyers defend an unlimited contingency fee system as a way to guarantee access to a lawyer for anyone with a grievance. Doctors view the same system as a potential unearned gold mine for a few lawyers who get huge settlements. We do not understand why a system that limits the legal fee to reasonable levels would not be more honest.

At the same time that we disagree on basic morality, we also tend to badly misunderstand one another's systems of controls. One hears lawyers repeatedly say that there would be no malpractice crisis if doctors would just do something to get rid of the "bad actors" in our profession. They fail to understand some important differences between our professions and how they are judged. A lawyer is expected to perform certain specific functions in a specific manner and his performance can be measured against those expectations. If he does what he is supposed to do, he might conceivably lose every case, but he would still be practicing acceptable law. If he does not do what he is supposed to do, his license to practice is at a risk and he is ultimately answerable to the Supreme Court of Florida. The severity of his punishment is determined by his peers through the Florida Bar Association. In contrast to that system, the controls which Florida's doctors have over one another are both much stricter and much looser than those of the Bar. They are stricter in that there is automatic peer review of most of what we do going on all the time, and our actions are judged not only by what specific actins were taken but also by the outcome of each action. They are looser in that we subject ourselves to much review on essentially a volunteer basis. If a physician is really a "bad actor," about the worst that we can do is throw him out of the medical society and suspend his hospital privileges. And if we take even those steps, the same Supreme Court that disciplines lawyers is behind the suspended doctor in guaranteeing his right to due process. The right to actually stop a doctor from practicing medicine or to alter any aspect of his practice outside the hospital setting is entirely out of the hands of his peers, except for the handful of physicians at the state government level. Only recently have even the physicians of the Board of Medical Examiners had much power to investigate and prosecute doctors who were obvious offenders.

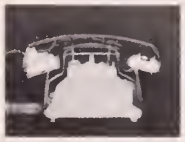
The same sorts of misunderstanding and confusion may be seen in the relationships between insurance companies and both doctors and lawyers and between members of the public and all three groups.

It is time we stop blaming one another and start working toward a solution. Physicians should take the initiative in this attempt by sitting down with the leadership of the other groups involved to exchange ideas and start the process of correcting misunderstandings on all sides. We might start by reminding ourselves that our opponents are probably acting in good faith and should be reasoned with — not shouted at — if we hope to make progress.

Henry L. Harrell Jr., M.D.
Associate Editor
Ocala



All of our medical knowle



MIST—Medical Information Service via Telephone.

It allows any practitioner in the United States to consult quickly with specialists at the University of Alabama Medical Center at UAB. So it helps physicians help their patients more effectively and quickly—without increasing the cost! MIST operates all day, every day.

By simply dialing a single toll-free number, a physician has immediate access to the latest research, clinical findings and protocols. It's a sophisticated communications link between physicians and professionals in all areas of health care.

MIST relies on the internationally recognized research and patient care centers at the University of Alabama Medical Center at UAB. Specialists in all fields are available to provide specific medical information and to discuss patient-related



dge is sitting on your desk.

problems whenever they arise.

MIST isn't a new service.

Physicians and other health care professionals have relied on it as a fast source of medical information and advice for over 17 years.

MIST is a valuable link for rapid access to medical information. So the next time you need help with patient problems, referrals or emergency information, consult us.

Consult With A Specialist, Call

MIST:

1 800 292-6508
IN ALABAMA

1 800 452-9860
OUTSIDE ALABAMA

UAB The University of Alabama at Birmingham

FAMILY PHYSICIANS—GENERAL SURGEONS—INTERNISTS

Why, How and When?

flexible sigmoidoscopy

A 1½ day post graduate course and workshop

- *ACCREDITATION:* Applied for 10½ hrs. credit; Category 1, AMA, and Prescribed credit.

SPONSOR: Medical Education Foundation of Miami
CO-SPONSORS: South Miami Hospital, Florida Gastroenterologic Society
COURSE DIRECTOR: John P. Christie, M.D.
REGISTRATION FEE: $225.00 (Syllabus and luncheon included)

Sat./Sun., Apr. 19-20, or Nov. 15-16, 1986

Sonesta Beach Hotel and Tennis Club

For information, write to:
6614 Miami Lakes Drive East
Miami Lakes, Florida
(305) 687-1367

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg Buccal/10 mg Oral/25 mg Oral

Methyltestosterone U.S.P. Tablets

ANDROID®/F

Fluoxymesterone U.S.P. Tablets, 10 mg.





My fair lady

After five years as a full-time academic cardiologist in a large teaching hospital, I decided to set up private practice in Florida. Moving from the "Big Apple" to a small agricultural community in the South was a great cultural shock and I found it difficult to adjust initially. I missed the teaching, research and contact with the residents. But the rewards of practice kept me going. Then one day Christine McLaughlin walked into my life.

A good physician is not supposed to get emotionally attached to his patients. But Christine has become an indelible part of my memory. This 78-year-old was one of my first patients. She suffered from congestive heart failure and had a permanent pacemaker, in which she had absolute faith. Mrs. McLaughlin was very sweet, sensitive and charming, an epitome of gentleness, ever so grateful to her doctor for prolonging and improving the quality of her life. She never complained about the prolonged waiting at the office or the repeated hospitalizations. Her only worry was about George, her loyal, devoted husband of 55 years. Her love and affection was amply reciprocated by him, who referred to her fondly as "My Fair Lady."

When admitted to CCU once, Christine marveled at the man-made wonders — the cardiac monitor, respirators, infusion pumps as well as the hard-working nurses and doctors. Even when dyspneic from pulmonary edema, her face had a rare grace, serenity and glow.

Then one day her pacemaker started failing and the generator had to be replaced by a surgeon. Afterwards, she was even more grateful to everybody and everything in life, a rare sentiment in this age. She was thrilled at this second chance at life.

On one follow-up visit, Christine gave me a little white envelope. Inside was this touching poem she wrote while in CCU, dangling between life and death. That is when George told me she was a one-time nominee for Poet Laureate of Florida. To this day I treasure it as the most precious gift of all. Later she would show me other sentimental poems on her still-born baby brother, her own newborn and so on.

Life Was Ebbing

My heart remained still
dangerously — until
skillful hands
restored its rhythmic beat.

Now I walk
with measured trend
in coronary cadence and,
count the precious hours.

Reaching out to touch my love
I feel in his warm embrace
the merging of his heart with mine
and our ever-present fear.

It was in the autumn of 1984. One day, George brought Christine to my office in a wheelchair.

"You don't feel like walking today, Chris?"

"I feel weak," she replied panting, in broken words. "Maybe I belong in the hospital."

From her ICU bed she admired the live oaks adorned with dreamy Spanish moss outside the window, shedding their withered leaves. She probably

visualized her own impending departure from the world she loved so much.

Her condition started worsening. First, it was pneumonia; then a stroke. More tests. . .CT Scans, EEG's, multiple venipunctures and so on. Uncomplaining as ever, she still maintained her dignity, stoic, calm, and cheerfulness.

Finally, it was an open battle with death. Her life was actually "ebbing away" every minute right in front of my very eyes. One night, she slipped into a coma. Although anticipated, the reality stunned me. By then, Christine McLaughlin had secured a permanent place in my heart. That day I prayed and prayed for her recovery. The thought that she may not talk or smile or write another poem again struck home hard.

But her time had come. Beside the bouquet of red roses from my garden, which I had brought her earlier, lay her frail lifeless body. Her last words when lucid were, "It is really wonderful that you came from a country on the other side of the world to touch my life and to keep me going for so long with your care and expertise. . .thank you doctor!"

With poetic intuition, that great lady must have sensed the insidious, relentless slipping into the unknown abysmal non-existence. . ."the subsiding riot of days. . .the keeping of the last appointment," in her own words.

M. P. Ravindra Nathan, M.D., FACCP, FACC
Brooksville

Wanted: magazines with no tobacco advertising

I noted with interest the advertisement for the Florida Medical Association Magazine Program and the accompanying letter by Dr. Henry M. Yonge in the November 1985 issue of *The Journal.*

Most of the magazines listed in the advertisement have a policy of accepting cigarette and/or tobacco advertising. I know, because I have been looking into this question from the standpoint of subscribing only to magazines which are free of cigarette and tobacco advertising in my waiting room. I suspect many physicians, like myself, would be interested in subscribing only to such magazines if a list of them were readily available.

It would be an excellent service to all such physicians in the FMA membership if the FMA Magazine Program would list magazines free of any tobacco advertising separately from tobacco-advertising magazines. It should not prove too difficult for the Magazine Program to draw up such lists.

This may seem to be a minor point, and yet it is not. Physicians are most intensely aware of the ravages to health wrought by tobacco. It is only through advertising that the tobacco industry maintains its unwanted grip on the lives and health of generation after generation of Americans. In a sense, when physicians carry magazines in their waiting-rooms which advertise tobacco products, they are also accessories in the advertising of those health-destroying substances. If they stop to think about it, I do not believe most physicians wish to aid the tobacco industry in such a manner, even if that aid is totally inadvertent.

I hope Dr. Yonge, and/or the Editorial Board of *The Journal of the FMA,* will strongly urge FMA Magazine Program to regularly provide a listing in *The Journal* of magazines free of any tobacco ads. My prediction is that such a list would become increasingly popular as it became known, and that as a result, it would become a powerful tool in helping physicians voluntarily rid their waiting-rooms of tobacco advertising.

R. Edward Dodge Jr., M.D.
Inverness

Editor's reply: Your letter has been forwarded to the FMA Magazine Program for its response and comments.

In the meantime, the AMA at its December meeting in Washington, D.C. passed a resolution calling for a total ban of tobacco advertising in newspapers and magazines. While most Americans now acknowledge the hazards to health of smoking, the action taken by the AMA has also stirred a storm of controversy mainly about whether a ban on advertising for a legal product like tobacco is constitutional or not. In any event, the AMA means business and will continue to spearhead the campaign for an eventual smokeless society.

History marches on

I am writing to inquire about *The Journal of the Florida Medical Association.* As you know, for many years there has been an historical issue every August. I frequently contributed to that and would like to contribute to it as in the past. I was recently told that articles of historical nature would be printed from time to time and reviewed much like any other article and there would no longer be any further specific historical issue.

What this essentially means is the kiss of death to any historical articles appearing in *The Journal of the FMA.* A few people may continue to write these from time to time including me but, as far as my overall development over the years of specific historical issues relating to the history of medicine in Florida, this will simply cease to happen.

I would take strong issue to this and believe that the historical issue published yearly by William Straight, M.D. was a real addition to the history of medicine in Florida and to *The Journal of the FMA* in particular. It was one of the few state medical journals which did this with any consistency or high quality. I would respectively request that this issue be re-examined with input from the board and executive committee and discussed at the next FMA general meeting.

Mark V. Barrow, M.D.
Gainesville

Editor's reply: Dr. Barrow absolutely has no reason to be alarmed. *The Journal of the FMA* has no plans to abandon the yearly historical issue and will continue the tradition as usual.

William Straight, M.D., the eminent Historical Editor for many years, finally called it quits last year and did not have the chance to put out a special issue in 1985. His successor, H. Frank Farmer Jr., M.D., of New Smyrna Beach, who has a Ph.D. in history, is now busy preparing a special historical issue on public health to be published this April. I am certain Dr. Barrow and other Florida physicians will enjoy this issue.

Let us all hang together

It is with great chagrin that I read the article by Drs. Stenger and Howington labeled "Preface" in *The Journal of the FMA*, November 1985.

Having been a member of the FMA since 1968, I would hardly expect the second to the last paragraph to slip by the editor. (The writer is referring to a criticism of the "walk-in clinic" as representative of the current medical climate which places primacy on quantity over quality of care and focuses mainly on patients with adequate health insurance). This "harpoon" is aimed at many in out-patient medicine and seems out of context to the lead article for an issue devoted to OB-GYN. The language is strong and ill advised, but speaks to the emotional upheaval being felt by some practitioners. Hardly does it seem appropriate to make blanket comments addressed at the state level.

True, medical care delivery is changing but, in spite of all the valid reasons on medicine's side, there are some good reasons expressed by the public for these changes. Changes will come and physicians must together attempt to direct these changes to benefit all. Medicine is a service vocation and must bend to provide that service without sacrifice of a good level of care. All of us try to give this, each in our own way. To single out one of two groups assures us that nothing will ever hang together for common good.

This letter is not a squeal of the harpooned but a plea that we should again attempt to rid our collective body of these ills. We need to look at all sectors to find workable solutions and when overtly wronged, stand firm as one. We will not be defeated unless we allow defeat. But, above all, we should not defeat ourselves.

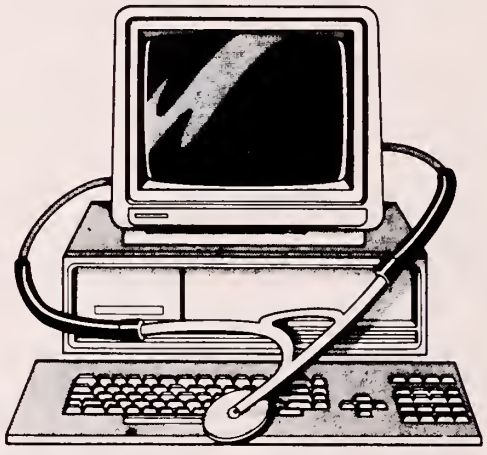
Linda A. Schlumbrecht, M.D.
Sarasota

Editor's reply: Drs. Stenger and Howington wrote their critical comments in the context of the drastic changes and commercialization that have taken place in medical practice. Their criticisms were spurred mainly by a concern to preserve the quality of medical care, and not to criticize a single segment of medicine.

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

FAIR OAKS HOSPITAL

AT BOCA/DELRAY

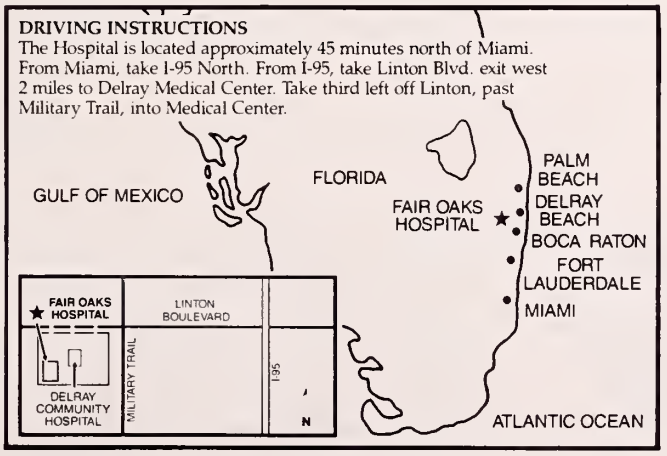
Fair Oaks is a beautiful, new private psychiatric hospital offering state-of-the-art specialized treatment programs including:

- Yale-trained staff of full-time senior psychiatrists
- Comprehensive bio-medical patient evaluation to ensure individually tailored treatment
- Staff to patient ratio of 2.5 to 1
- Neuropsychiatric Evaluation Unit
- Depression evaluation and treatment
- Adolescent treatment program including a school program
- Addiction treatment program including medical detoxification from cocaine and opiates
- Florida affiliate of 800-COCAINE National Helpline
- Adult Treatment Unit
- Eating disorder program for treatment of anorexia, bulimia and severe obesity.

For more information, call or write:

Fair Oaks Hospital at Boca/Delray
5440 Linton Blvd.
Delray Beach, FL 33445
(305) 495-1000

DRIVING INSTRUCTIONS
The Hospital is located approximately 45 minutes north of Miami. From Miami, take I-95 North. From I-95, take Linton Blvd. exit west 2 miles to Delray Medical Center. Take third left off Linton, past Military Trail, into Medical Center.



Fair Oaks Hospital at Boca/Delray is managed by Psychiatric Institutes of America, which is a subsidiary of National Medical Enterprises.

THE SECOND ANNUAL
NEURO-ONCOLOGY UPDATE — 1986

Presented by

The Division of Neuro-Oncology
Department of Neurology
College of Medicine
University of South Florida

March 14-15, 1986
Clearwater Beach, Florida

SYMPOSIUM ON:

Pediatric Brain Tumors
Management of Adult Primary Malignant Tumors and Brain and Spinal Cord Metastasis
Experimental Therapy: Intracarotid Chemotherapy, Intrastitial Radiation, Immunotherapy — Interferon, Monoclonal Antibodies and Hyperthermia

GUEST SPEAKERS:

Jeffrey C. Allen, M.D.
Memorial Sloan-Kettering Cancer Center

David R. MacDonald, M.D., FRCP
Victoria Hospital and London Regional Cancer Center

M.S. Mahaley, Jr., M.D., Ph.D.
University of North Carolina School of Medicine

WIlliam M. Wara, M.D.
University of California, San Francisco

and USF FACULTY

COURSE HOURS:

12 Hours Category 1, AMA

FEE:

$200/$100 Practicing Physicians/Physicians in Training Before February 14, 1986

For Further Information, Please Contact:

Surasak Phuphanich, M.D.
Course Director
Medical Center, Box 69
12901 N. 30th Street
University of South Florida
Tampa, Florida 33612
(813) 974-3771

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
JANUARY 1986, Vol. 73, No. 1

Laser therapy of primary lung cancer

Keith W. Chandler, M.D., Allan L. Goldman, M.D. and Richard G. Connar, M.D.

ABSTRACT: During a ten-month period, 13 patients with lung cancer occluding major airways underwent a total of 17 Neodymium-YAG (Yttrium-Aluminum-Garnet) laser treatments to palliate symptoms of dyspnea or postobstructive pneumonia. Ten patients improved as a result of photoresection of endobronchially visible cancers. Two patients, whose symptoms remained unchanged in spite of treatment, had no visually apparent restoration of luminal patency. In one of them the treatment was abbreviated for technical reasons. One patient died during treatment owing to bronchial hemorrhage. Neodymium-YAG laser therapy can be an effective means of palliating the distressing symptoms of selected patients with endobronchial malignancies.

The Authors
KEITH W. CHANDLER, M.D.
ALLAN L. GOLDMAN, M.D.
RICHARD G. CONNAR, M.D.

Dr. Chandler is Assistant Professor of Medicine, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, University of South Florida College of Medicine and Staff at James A. Halley Veterans Hospital, Dr. Goldman is Professor and Director, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, University of South Florida College of Medicine, and Dr. Connar is Professor and Chairman, Department of Surgery, University of South Florida College of Medicine, Tampa.

Lung cancer is the most common internal malignancy in men and soon will surpass breast cancer in women. Many of these tumors originate or extend into the tracheobronchial tree where they obstruct major airways, causing dyspnea and cough, and can result in atelectasis or obstructive pneumonitis. If the patient is an operative candidate and the lesion is resectable then surgery is the treatment of choice. If surgery is not advisable then radiation therapy should be considered. In selected circumstances, predominantly with small cell carcinoma, chemotherapy should be considered.

Many patients with lung cancer have major airway involvement and fail to respond adequately to previously mentioned measures. In these patients, the airway obstruction can cause substantial and even disabling symptomatology. In the past there was very little that could be offered to these patients. Recent results with the Neodymium-YAG laser have been encouraging. The laser (light amplified stimulated emission of radiation) emits light energy which is converted into heat energy which can be used to locally ablate tissue. We present our results in 13 consecutive patients seen and treated in the last ten months.

Materials and methods • Patients with cancer obstructing a "major" airway who were not considered surgical candidates and in whom all reasonable radiotherapeutic and chemotherapeutic options had been exhausted were considered candidates for laser photoresection therapy. All had airway obstruction resulting in dyspnea, atelectasis or obstructive pneumonitis. This study had previously been reviewed and approved by the University of South Florida College of Medicine Institutional Review Board and the FDA. Potential risks and benefits

were explained and patients voluntarily agreed to participate in the study and signed voluntary informed consents.

Patients were kept NPO for several hours prior to the procedure and generally received preoperative atropine 0.6 mg and Demerol 50 mg intramuscularly. The procedure itself was conducted in the Endoscopy Suite at Tampa General Hospital using topical lidocaine anesthesia. Frequently, intravenous Valium was also used. On occasion, patients were artificially ventilated during the procedure. In one patient, the procedure was performed through a rigid bronchoscope. In the others, the patient was intubated with an 8.5 mm endotracheal tube through which an Olympus BF1TR fiberoptic bronchoscope was passed. This has a 2.6 mm working channel. A Medilase II YAG coagulation laser manufactured by MBB Angewandte, a subsidiary of Messerschmitt-Bolkow, was utilized. This machine emits a continuous wave laser with a wavelength of 1,064 nm and an adjustable power output. It utilizes a helium neon aiming laser of 630 nm wavelength. The laser beams were projected via a teflon coated 0.6 mm quartz glass fiber which served as the light transmission system. The optical fiber was inserted through the working channel of the bronchoscope. The tip of the quartz fiber was kept 5-10 mm from the target. Protective lenses were worn by the personnel and the patient or were placed directly over the eyepieces of the bronchoscope. The obstructed airway was visualized and the tumor was ablated as much as possible under direct visual control. The power settings on the laser varied from 40-70 watts and the pulses varied form 0.4-0.75 seconds. Necrotic tumor was debrided with biopsy forceps. Patients received supplemental oxygen therapy during frequent respites between periods of laser photoresection. Patients underwent continuous electrocardiographic monitoring. Following the procedure they were observed either in the Intensive Care Unit or in their rooms.

Results • Table 1 summarizes our results. Patient 1 had small cell carcinoma of the lung and had previously received therapeutic irradiation and chemotherapy. All other patients had squamous cell carcinoma of the lung. Seven patients had obstruction of the right main stem bronchus, three patients had obstruction of the left main stem bronchus (one of whom also had an obstruction of the bronchus intermedius), two patients had obstruction of both main stem bronchi, and one patient had obstruction of the basal bronchi on the right.

The energy applied in Joules ranged from 748-17,536. Although most patients underwent a single treatment, two patients had two treatments and one patient required three treatments during the hospitalization. All patients except 5, 6, and 12 had some patency of the airways restored and noted improvement in symptoms. The only complication was in patient 12 who developed moderate bleeding shortly after beginning therapy. Because there was nothing further to offer this severely symptomatic patient, the procedure was continued in the hope that bleeding could be photocoagulated and a lumen restored. He subsequently developed uncontrollable bleeding and died as a direct complication of the procedure. All of the remaining patients reported symptomatic improvement which in patients 2 and 8 was fair and in the remaining patients was good to excellent. The improvement was in disabling symptoms and in airflow heard on auscultation over the involved areas of the lung. Most also had improvement of the chest radiograph if it had previously shown atelectasis. At the current time, no patients have required retreatment but undoubtedly some will in the future. There is little long-term follow-up available because insufficient time has elapsed. Therefore, the long-term results of this new modality of therapy are still under investigation.

Discussion • There are three types of lasers currently available for medical use. The carbon dioxide laser emits radiation in the infrared region with a wavelength of 10,600 nm. Unfortunately, this very long wavelength cannot be conducted by a quartz monofilament and so its use has been restricted to rigid endoscopy systems. The argon laser delivers blue-green light with a wavelength of 514 nm which can be conducted by a flexible quartz monofilament through a fiberoptic bronchoscope. However, the blue-green light is strongly absorbed by hemoglobin. Because some bleeding is nearly always present during laser photoresection, the argon laser is relatively ineffective. The Neodymium-YAG laser delivers radiation in the near infrared region with a wavelength of 1,064 nm and is capable of being conducted by a quartz monofilament through a flexible fiberoptic bronchoscope.[1] Because it is not absorbed by hemoglobin it results in greater tissue penetration and is much more useful for ablation of tumor tissue.

Some patients with lung cancer have locally aggressive disease which causes significant and progressive respiratory symptomatology. This can cause a slow and agonizing death. Although radiotherapy or chemotherapy can benefit some of these patients, others do not respond initially while many develop recurrent disease after having received the maximally tolerated dose of radiation. Several recent studies have shown that laser photoresection therapy can be effective in palliating the symptoms of such

Table 1. — Patient Characteristics, Delivered Energy, Outcome of Neodymium-YAG Laser Photoresection of Endobronchial Malignant Obstruction.

Patient	Cell Type	Site of Obstruction	Treatment (Joules)	Results
1	Oat cell	Bilateral mainstem	748	Improved
2	Squamous cell	Right mainstem	(1) 1,221 (2) 2,244	Improved
3	Squamous cell	Right mainstem	2,159	Improved
4	Squamous cell	Right mainstem	(1) 5,475 (2) 10,160	Improved
5	Squamous cell	Left mainstem	6,286	Unchanged
6	Squamous cell	Left mainstem	1,760	Procedure terminated because of damage to light guide
7	Squamous cell	Right basal bronchi	993	Improved
8	Squamous cell	Right mainstem	(1) 9,224 (2) 5,325 (3) 2,987	Improved
9	Squamous cell	Right mainstem	2,020	Improved
10	Squamous cell	50% occlusion left mainstem 95% occlusion bronchus intermedius	4,815	Improved
11	Squamous cell	Bilateral mainstem	4,814	Improved
12	Squamous cell	Right mainstem	6,677	Expired, massive hemoptysis
13	Squamous cell	Right mainstem	7,236	Improved

patients.[2-5] Although symptoms can frequently be palliated, the procedure itself is potentially dangerous and can be complicated by perforation of a bronchus, massive hemorrhage, respiratory failure, pneumonia or combustion of products in the airways such as the fiberoptic bronchoscope or the endotracheal tube. In our series there was one fatality from massive hemoptysis. Other series have reported similar results.

In most patients the procedure was very well tolerated and produced good to excellent results. It undoubtedly will be necessary to retreat some of these patients as the tumor regrows. Laser therapy is not curative and should solely be thought of as palliative. Undoubtedly some of these patients, as they live longer, will develop other complications of their malignancy. Although time and experience will eventually determine the precise indications for this new modality of therapy, some guidelines are beginning to emerge. In general, lesions that are considered favorable include those located in the main stem bronchi or trachea, tumors that are endobronchial, polypoid, not completely obstructing the lumen, short in length, and associated with functional lung distal to the lesion. Unfavorable lesions are those which cause extrinsic compression, total obstruction of the airway, are lobar or segmental in location or are extensive, i.e., more than 4 cm in length. Some of our patients who had complete obstruction responded very well, but required multiple treatments.

Other potential indications for laser therapy include removal of granulation tissue and sutures and vaporization of nonflammable foreign bodies. Laser therapy is a useful addition to our armamentarium for the treatment of lung cancer. Patients who have persistent obstruction of a major airway not responsive to or are not candidates for other forms of therapy should be considered as possible candidates for laser therapy.

References

1. McDougall, J.C. and Cortese, D.A.: Neodymium-YAG Laser Therapy of Malignant Airway Obstruction: Preliminary Report, Mayo Clin. Proc. 58:35-39, 1983.
2. Dumon,J F.; Reboud, E.; Garbe, L.; Aucomte, F., and Meric, B.: Treatment of Tracheobronchial Lesions by Laser Photoresection, Chest 81:278-284, 1982.
3. Arabian, A and Spagnolo, S.V.: Laser Therapy in Patients with Primary Lung Cancer, Chest 86:519-523, 1984.
4. Hetzel, M.R.; Millard, F.J.C.; Ayesh, R.; Bridges, C.E.; Nanson, E.M.; Swain, C.P., and Williams, I.P.: Laser Treatment for Carcinoma of Bronchus, Br. Med. J. 286:12-16, 1983.
5. Gelb, A.F. and Epstein, J.D.: Laser in Treatment of Lung Cancer, Chest 86:662-666, 1984.

- Dr. Chandler, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, and Department of Surgery, University of South Florida College of Medicine and Tampa General Hospital, c/o 13000 N. 30th Street (111C), Tampa 33612.

Soft tissue infections in Florida due to marine Vibrio bacteria

Richard Howard, M.D., Ph.D., Bruce Brennaman, M.D. and Spencer Lieb, M.P.H.

ABSTRACT: Twenty-nine patients, 26 men and three women, had soft tissue infections caused by marine vibrio bacteria between October 1, 1981 and June 30, 1985. The infection in 27 patients developed following exposure to seawater usually in combination with a chronic ulcer, injury, laceration or insect bite. One patient became infected after eating raw oysters and another injured her elbow but had no apparent exposure to ocean water. Fourteen patients had a preexisting illness that might have predisposed them to the infection. Seven patients had necrotizing soft tissue infections (six had an underlying illness) and required debridement in addition to antibiotic therapy. Eight patients died (all had an underlying illness). All patients developed signs and symptoms of cellulitis and/or necrosis within 48 hours of exposure to seawater. Marine vibrio infections should be considered in all patients who develop soft tissue infections following exposure to seawater.

The Authors
RICHARD HOWARD, M.D., Ph.D.
BRUCE BRENNAMAN, M.D.
SPENCER LIEB, M.P.H.
Drs. Howard and Brennaman and Mr. Lieb are with the University of Florida College of Medicine, Gainesville and Department of Health and Rehabilitative Services, Tallahassee.

Vibrio cholerae O-group 1, the bacterium that causes cholera, is of most interest to clinicians, microbiologist, and public health officials because of its association with infectious gastroenteritis. Other vibrios were thought to be nonpathogenic and were dismissed as "non-agglutinable vibrios" since they did not agglutinate in V. cholerae O-group 1 antiserum or as "non-cholera vibrios." Investigators have realized only for the past 15 years that noncholera vibrios can cause infections in humans. These other Vibrio species including V. cholerae non-O group 1, V. vulnificus, V. parahaemolyticus, and V. alginolyticus can cause gastroenteritis, septicemia with rapid death, and soft tissue infections.[1]

The noncholera vibrios are halophilic marine bacteria that can be found in coastal waters and estuaries throughout the world. These bacteria can also be found in fish, shellfish, and crustaceans. Noncholera marine Vibrio infections are currently reportable to the Florida Department of Health and Rehabilitative Services.

Patients and methods • From October 1, 1981 through June 30, 1985, 29 patients with primary soft tissue infections caused by marine vibrios were reported to the Communicable Disease Epidemiology Program of the Florida Department of Health and Rehabilitative Services or were seen at Shands Hospital of the University of Florida. Vibrio investigation case report forms were filled out by Department investigators. Where necessary, the patient's physician was contacted. Hospital charts were reviewed when available. Six of the seven patients who had necrotizing infections were previously reported elsewhere.[2] Another 22 patients with nonnecrotizing infections are added here. Most cultures were con-

Table 1. — Marine Vibrio Wound Infections, 1981-1985, In Florida.

No.	Age	Sex	Predisposing Cause	Vibrio Species	Died	Necrotizing Infection	Comment
1	63	M		Parahaemolyticus	No	No	Bitten by stingray while clamming, walked in seawater with open wound.
2	66	M	Alcohol abuse, diabetes, arthritis	Vulnificus	No	No	Had eaten raw oysters, developed left foot infection
3	16	M		Parahaemolyticus	No	No	Cellulitis in finger in which fish fin was imbedded
4	54	M		Alginolyticus	No	No	Sustained puncture wound of foot while surfing
5	75	M	Stomach cancer, malnutrition	Vulnificus (from wound and blood)	Yes	No	Lacerated wrist while shucking oysters with oyster knife
6	64	M	Cirrhosis	Vulnificus (from wound and blood)	Yes	No	Bitten on finger by crab, pain and erythema 4 hours later, septicemia led to cellulitis in legs
7	92	M	Heart failure	Vulnificus (from wound and blood)	Yes	No	Lacerated thumb while cleaning fish
8	61	M	Cirrhosis, diabetes	Vulnificus	Yes	Yes	Had been eating raw oysters and bathing in seawater, injured left leg
9	17	M		Cholera non-O group 1	No	No	Lacerated knee on rock while swimming
10	19	M		Alginolyticus	No	No	Fish hook lodged in thumb, professional saltwater fisherman
11	45	M	Heart disease	Parahaemolyticus	No	No	Injured foot on concrete block immersed in seawater
12	57	M		Vulnificus	No	No	Saltwater fisherman cut thumb while fishing
13	80	F	Osteoarthritis, peptic ulcer	Cholera non-O group 1	No	No	Injury to elbow, no apparent exposure to seawater
14	29	M		Parahaemolyticus	No	No	Severe leg injury in auto accident, thrown into ocean, amputation required
15	35	M		Vulnificus, parahaemolyticus	No	No	Lacerated foot on rocks in ocean
16	90	M		Vulnificus	No	No	Hit hand on fence adjacent to ocean inlet

17	29	M		Alginolyticus	No	No	Jumped into ocean in shallow water lacerating hands and feet
18	37	M		Parahaemolyticus, alginolyticus	No	No	Punctured finger while shucking oysters
19	7	M		Vulnificus	No	No	Catfish barb became imbedded in thigh while fishing
20	10	M		Alginolyticus	No	No	Injured foot on rocking chair, lived near ocean
21	60	F		Vulnificus	No	No	Fell and hit leg on boat while crabbing wading in seawater
22	61	M	Metastatic lung cancer, chemo-therapy	Parahaemolyticus (from wound and blood	Yes	No	Cellulitis, edema and bullae on foot
23	43	M	Cirrhosis	Parahaemolyticus	No	Yes	Ate raw oysters 24 hours before developing necrotizing infection of leg — no prior injury to leg
24	69	M	Osteoarthritis, taking steroids	Vulnificus	No	Yes	Fishing in estuary of Atlantic ocean, waded into water, later bitten on leg by fire ants, still had on wet pants, developed necortizing infection of ankle
25	75	M		Vulnificus	No	Yes	Gulf coast fisherman stung by insect on back of hand, developed necrosis over dorsum of hand
26	72	M	Myeloma, neutro-penia	Vulnificus (from wound and blood)	Yes	Yes	Fishing in estuary of Gulf of Mexico, while cleaning fish sustained puncture wound to lower leg, developed necrotizing infection of leg, died of Pseudomonas aeruginosa pneumonia
27	63	F	Rheumatoid arthritis, taking steroids	Not identified	Yes	Yes	Lacerated ankle while swimming in Gulf of Mexico near oyster bed, part of oyster shell became imbedded in ankle
28	51	M	Cirrhosis, chronic venous ulcer	Vulnificus (from wound and blood	Yes	Yes	Wading in ocean while fishing for crabs, developed necrotizing infection of leg, amputation required, S. marcescens cultured from blood at postmortem examination
29	60	M	Diabetes mellitus	Not identified	No	No	Waded in Gulf of Mexico after superficial laceration of leg, developed cellulitis and bullae, right lower extremity, responded to antibiotics

firmed by the Office of Laboratory Services, Department of Health and Rehabilitative Services, and/or Centers for Disease Control, Atlanta.

Results • Twenty-six of the 29 patients were men and three were women. Their ages ranged from seven to 92 years, median 58.6 years (Table 1). There were 27 white and two black patients.

Fourteen patients had a preexisting illness that might have predisposed to the Vibrio infection (Table 1). Five patients had cirrhosis due to chronic alcoholism; three patients had cancer; four patients had arthritis of whom two were taking steroids; two patients had heart failure, one had diabetes mellitus, and one patient had major trauma. Underlying illnesses were more common in patients with severe necrotizing infections (six of seven patients) and in patients who died (eight of eight patients).

All soft tissue infections began in the lower legs and feet or in the hands and were usually the result of a puncture would or bite by a marine animal or by an instrument used to clean shellfish (Table 1). Other patients developed Vibrio infections at sites of insect bites allowed to come in contact with seawater. Necrotizing infection developed in the leg of one patient after a chronic venous ulcer came in contact with seawater. Cellulitis began four hours postexposure. All patients had symptoms and signs of cellulitis or a necrotizing infection within 48 hours of exposure.

Cellulitis was characterized by intense erythema, often extending far from the original site of injury. Extensive edema and bullae were seen in patients with more severe infections. Seven patients developed necrotizing infections.

Eight of the 29 patients died. Four (57.1%) of the seven of patients with necrotizing infections and four (18%) of the 22 patients without necrosis died (Table 1). Death occurred in each of the six patients with septicemia. Two other patients died of nosocomial infection (Pseudomonas pneumonia, Serratia septicemia); the Vibrio was not reisolated after antibiotic therapy. All patients who died were older than 50 years.

V. vulnificus was the most common organism, isolated from 14 patients' wounds. V. parahaemolyticus was cultured from 8 patients, V. alginolyticus from 5 patients, and non-O group 1 V. cholerae from two patients. The Vibrio species was not identified in two patients. Multiple organisms were isolated from two patients. Six patients also had the bacterium cultured from blood (Table 1).

The treatment of vibrio soft tissue infections consisted of antibiotics, supportive treatment and debridement where necrosis occurred. Amputation was required to control the infection in one patient. Another patient underwent amputation because of severe trauma.

Discussion • It has only been since 1964 that the Centers for Disease Control received Vibrio isolates from extraintestinal sites, wounds and blood.[1] These early isolates were later identified as V. vulnificus. The first published indication that V. parahaemolyticus might also cause extraintestinal infections appeared in 1969.[3] V. alginolyticus was not thought to be a human pathogen until 1973 when six isolates from soft tissue infections originally identified as V. parahaemolyticus by Twedt in 1969 were found to be V. alginolyticus.[4] V. vulnificus is among the more recently identified Vibrio species. It is distinguished from V. parahaemolyticus and V. alginolyticus by its ability to ferment lactose.[16,17] V. vulnificus can cause primary bacteremia and soft tissue infections. Rarely, it can also cause gastroenteritis.[5]

Non-O group 1 cholera vibrios are halophilic marine bacteria that can be cultured from seawater, estuaries, and seafood. Septicemia and soft tissue infections have been described worldwide including North America, South America, Europe, Asia, and Australia.[1,6,7] Most of the reports have appeared in the American literature with most infections originating from states bordering the Gulf of Mexico. Infections tend to occur between May and October, probably because that is when most people go to the seashore.[1,6]

V. vulnificus is the most common Vibrio identified as a cause of septicemia and soft tissue infections. It is also most commonly associated with necrotizing infections.[2,8]

Soft tissue infections caused by marine vibrios usually begin in preexisting ulcers or wounds that are exposed to seawater or in puncture wounds or lacerations caused by marine animals, or instruments used in preparing seafood. Thus far reports of approximately 75 primary soft tissue infections have appeared. Eighteen of these patients also had tissue necrosis.[1,2,5,8-16]

The cellulitis is characterized by intense edema and erythema and pain at the site of infection. In more severe infections bullae may appear. The erythema may persist even after control of the infection with antibiotics and may be due to a toxin elaborated by the bacteria. The infection may progress to frank necrosis. Necrosis usually involves only the skin and underlying subcutaneous fat. There is only one reported case of necrotizing myositis.[13]

Marine vibrios can also cause primary septicemia. Up to 75% of patients with primary septicemia have metastatic skin lesions.[1,17] These lesions begin as erythematous or ecchymotic areas usually on the extremities, may progress to vesicle and bulla formation and still later to necrotic ulcers. They resemble erythema multiformae, tend to be multiple and seldom become more than 2 cm in diameter. We have excluded such lesions from this series. We have included only one patient (Case 23)

who presented primarily with cellulitis involving a large portion of the leg and who had no other obvious skin sites involved. He ate oysters and probably became septic from that source, subsequently developing a soft tissue infection.

Ninety-one percent of patients with primary septicemia have a history of chronic disease, usually alcoholism, cirrhosis, or diabetes mellitus. A history of eating raw oysters can be obtained from 87% of patients within the two weeks preceding the illness — usually within 24 hours. Primary septicemia has a mortality rate of 46%.[1]

Soft tissue infections can also lead to septicemia. Septicemia occurred in six (21%) of the 29 patients in this series. All patients in whom sepsis developed had chronic illness. Patients with necrotizing infections were more likely to have septicemia (33%).

Like patients with primary septicemia caused by marine vibrios, patients with soft tissue infections frequently have chronic underlying illnesses and tend to be in the older age group. Fourteen (48%) of the 29 patients had an underlying illness of which alcoholism and cirrhosis (five patients) were the most common. Patients with necrotizing infections were more likely to have an underlying illness (six of seven patients) as well as patients who died (seven of seven).

Septicemia and soft tissue infections caused by marine vibrios can occur extremely rapidly after exposure. The typical patient in whom septicemia develops is a man in the mid-fifties who has chronic liver disease, usually alcoholism and cirrhosis, and who eats raw oysters. Fever, chills, nausea and vomiting, abdominal pain and hypotension develop within 12 to 24 hours and in 46% death occurs within 18 to 48 hours. Similarly, soft tissue infections occur extremely rapidly following exposure. The infection usually begins with pain at the site followed rapidly by erythema and edema. In one patient, these changes occurred within four hours of injury to his finger by a crab. Virtually all patients had signs and symtpoms within 24 hours of exposure.

Inoculation of V. vulnificus subcutaneously into mice results in a severe soft tissue infection with marked edema. Death occurs as early as four hours after inoculation.[18] In those animals that survive, tissue necrosis occurs within 48 hours (unpublished observations). By inducing liver injury with CCl_4 or by administrating iron in the form of ferric ammonium citrate together with the bacteria the LD_{50} is reduced from 5×10^6 cfu to as few as 10 cfu (unpublished observations). Oliver[19] has found that exogenous iron also increases the lethality of intraperitoneally administered V. vulnificus. People subject to marine vibrio infections frequently have disorders of iron metabolism and cirrhosis or hemochromatosis.

The organism can be recovered from the skin and subcutaneous tissue, bullae and, frequently, from the blood. While the genus Vibrio is easy for most clinical laboratories to identify, the species can be difficult because of fastidious growth requirements for the fermentations used to determine species.

The treatment of soft tissue infections caused by marine vibrios consists of antibiotics, intravenous fluids, and debridement when tissue necrosis has occurred. Because these infections can extend rapidly, probably all patients should initially be treated in the hospital with intravenous antibiotics. Resuscitation may require large amounts of intravenous fluids in seriously ill patients.

Marine vibrios are sensitive to a wide range of antibiotics.[20] V. vulnificus is sensitive to penicillin. V. parahaemolyticus and V. alginolyticus may have beta lactamase actively and thus be resistant to penicillin.[21] Nevertheless, many are sensitive to penicillin, ampicillin, carbenacillin, and the cephalosporins. Tetracycline appears to be the preferred antibiotic for V. parahaemolyticus and V. alginolyticus and provides adequate coverage for V. vulnificus.[5,22] Most vibrious are also sensitive to erythromycin. In a study by Hollis et al[22] 33 isolates of V. vulnificus were sensitive to penicillin, ampicillin, carbenicillin, cephalothin, chloramphenicol, gentamicin, tetracycline, nitrofurantoin and sulfasoxazole.

These infections should be considered in anyone who has developed a soft tissue infection after coming in contact with seawater or uncooked seafood. Cases have been seen at inland sites in patients who returned from vacations near the ocean.

Morris and Tenney [20] have warned that in vitro laboratory sensitivity testing does not necessarily correlate with results of antibiotic administration for experimental infections in mice.

Summary • Twenty-nine patients, 26 men and three women, had soft tissue infections caused by marine vibrio bacteria between October 1, 1981 and June 30, 1985. The infection in 27 patients developed following exposure to seawater usually in combination with a chronic ulcer, injury, laceration or insect bite. One patient became infected after eating raw oysters and another injured her elbow but had no apparent exposure to ocean water. Fourteen patients had a preexisting illness that might have predisposed them to the infection. Seven patients had necrotizing soft tissue infections (six had an underlying illness) and required debridement in addition to antibiotic therapy. Eight patients died (all had an underlying illness). All patients developed signs and symptoms of cellulitis and/or necrosis within 48 hours of exposure to seawater. Marine vibrio infec-

tions should be considered in all patients who develop soft tissue infections following exposure to seawater.

References

1. Blake, P.A.: Diseases of humans (Other Than Cholera) Caused by Vibrios, Ann Rev. Microbiol. 34:341-367, 1980.
2. Howard, R.J.; Pessa, M.E.; Brennaman, B.H., and Ramphal, R.: Necrotizing Soft Tissue Infections Due to Marine Vibrios, Surgery, in press.
3. Twedt, R.M.; Spalding, P.L., and Hall, H.E.: Morphological, Cultural, Biochemical, and Seriological Comparison of Japanese Strains for Vibrio parahemolyticus with Related Cultures Isolated in United States, J. Bacteriol. 98:S11-S18, 1969.
4. Zen-Yoji, H.; LeClair, R.A., and Ohta, K., et al: Comparison of Vibrio parahemolyticus Cultures Isolated in United States with Those Isolated in Japan, J. Infect. Dis. 127:237-241, 1973
5. Bachman, B; Boyd, W.P., Jr., and Lieb, S., et al: Marine Noncholera Vibrio Infections in Florida, South. M.J. 76:296-299, 1983.
6. Blake, P.A., Herson, M.H., and Weaver, R.E., et al: Disease Caused by Marine Vibrio. Clinical Characteristics and Epidemiology, New England J. M. 300:1-5, 1979.
7. McSweeney, R.J. and Forgan-Smith, W.R.: Wound Infections in Australia from Halophilic Vibrios, Med. J. Aust. 1:896-897, 1977.
8. Mautner, L.S. and Halmos, V.: Cutaneous Infection with Marine Vibrio, Canad. M.A. J. 121:1584-158S, 1979.
9. Spark, R.P.; Fried, M.L., and Perry, C., et al: Vibrio Aginolyticus Wound Infection: Case Report and Review, Ann. Clin. Lab. Sci 9:133-137, 1979.
10. Beckman, E.N.; Leonard, G.L., and Castillo, L.E., et al: Histopathology of Marine Vibrio Wound Infections, Am. J. Clin. Path. 76:76S-772, 1981.
11. Fernandez, C.R. and Pankey, G.A.: Tissue Invasion by Unnamed Marine Vibrios, JAMA 233:1173-1176, 197S.
12. Castillo, L.E.; Winslow, D.L., and Pankey, G.A.: Wound Infection and Septic Shock Due to Vibrio vulnificus, Am. J. Trop. Med. Hyg. 30:844-848, 1981.
13. Kelly, M.T. and McCormikck, W.F.: Acute Bacterial Myositis Caused by Vibrio Vulnificus, JAMA 246:72-73, 1981.
14. Roland, F.P.: Leg Gangrene and Endotoxin Shock Due to Vibrio parahemolyticus — an Infection Acquired in New England Coastal Waters, New England J. M. 202:1306, 1970.
15. Bonner, J.R.; Coker, A.S., and Berryman, C.R., et al: Spectrum of Vibrio Infections in Gulf Coast Community, Ann. Int. Med. 99:464-469, 1983.
16. Thorsteinsson, S.B.; Minuth, J.N., and Musher, D.M.: Clinical Manifestations of Halophilic Non-cholera Vibrio Infections, Lancet 2:1283-1284, 1974.
17. Tacket, C.O.; Brenner, F., and Blake, P.A.: Clinical Features and Epidemiological Study of Vibrio vulnificus, J. Infect. Dis. 149:S58-S61, 1984.
18. Poole, M.D. and Oliver, J.D.: Experimental Pathogenicity and Mortality in Ligated Loop Studies of Newly Reported Halophilic Lactose-Positive Vibrio sp, Infect. Immun. 20:126-129, 1978.
19. Wright, A.C.; Simpson, L.D., and Oliver J.D.: Role of Iron in Pathogenesis of Vibrio vulnificus Infections, Infect. Immun. 34:S03-S07, 1981.
20. Morris, J.G. Jr. and Tenney, J.: Antibiotic Therapy for Vibrio vulnificus Infections, JAMA 2S3:1121-1122, 198S.
21. Joseph, S.W.; DeBell, R.M., and Brown, W.P.: In vitro Response to Chloramphenicol, Tetracycline, Ampicillin, Gentamicin, and Beta Lactamase Production by Halophilic Vibrios from Human and Environmental Sources, Antimicrob. Agents Chemother. 13:244-248, 1978.
22. Hollis, D.G.; Weaver, R.E., and Baker, C.N., et al: Halophilic Vibrio Species Isolated from Blood Cultures, J. Clin. Microbiol. 3:42S-431, 1976.

- Dr. Howard, University of Florida College of Medicine, Box J-286, JHMHC, Gainesville 32610.

Neurosarcoidosis presenting as an intracranial mass

David W. Cahill, M.D., Ernesto Botero, M.D. and Walker L. Robinson, M.D.

ABSTRACT: A case of primary intracranial sarcoidosis is presented. The case mimicked a subfrontal meningioma by all radiographic criteria and was mistaken for a rare granular cell myoblastoma by both light and electron microscopy. Only clinical course and rebiopsy ultimately established the correct diagnosis. Sarcoidosis presenting as an intracranial mass lesion is reviewed and the role of neurosurgery in the diagnosis and therapy of the condition is discussed.

Sarcoidosis involves the nervous system in about 5% of cases.[1] At least 4/5 of these patients manifest the disease in other organ systems before the neuraxial disease becomes evident.[2] Nonetheless a small number of patients present with neurologic complaints and may have no evidence of extraneural disease even after thorough investigation.[3-8]

The great majority of patients suffering from neurosarcoidosis present with symptoms and signs produced by chronic granulomatous basilar meningitis. Hence, cranial neuropathies, hydrocephalus, and endocrine disturbances secondary to hypothalamo-hypophyseal dysfunction are the usual neurologic findings.[1,9,10]

Neurosarcoidosis, however, may occasionally present as a focal mass lesion. The history and physical examination may be suggestive of intrinsic tumor and even advanced laboratory and radiological techniques may fail to reveal the correct diagnosis.

Case report • Six months prior to admission, a 36-year-old black male became separated from his wife and withdrawn from friends and family. Two months prior to admission, he was admitted to the psychiatric ward in another hospital with the diagnoses of major depression and anxiety disorder and was begun on haloperidol. Over the next month he became increasingly lethargic, his memory deteriorated and he became disoriented. A CT scan was obtained after which he was begun on dexmethasone and transferred to our hospital.

Upon arrival, he was lethargic and apathetic. He complained of no difficulty with vision and had no significant endocrine history other than impotence unassociated with libidinal loss.

His vital signs and general physical examination were normal. On neurologic examination, he was disoriented with severely impaired memory, calculations, and judg-

The Authors
DAVID W. CAHILL, M.D.
ERNESTO BOTERO, M.D.
WALKER L. ROBINSON, M.D.
Dr. Cahill is Director of Neurosurgery at the University of South Florida College of Medicine, Dr. Botero is Chief Resident in Neurosurgery and Dr. Robinson is Associate Professor of Neurosurgery at the University of Maryland School of Medicine.

ment. There were venous pulsations in neither fundus but no papilledema. Visual field examination was unremarkable. General motor and sensory examination was normal but he had a mildly ataxic gait and was unable to tandem walk. Reflexes were symmetric with equivocal bilateral Babinski signs.

A complete laboratory evaluation, electrocardiogram, and chest radiograph were normal. Serum thyroid hormone and fasting cortisol levels were normal and prolactin was minimally elevated. This was thought to be secondary to haloperidol therapy. Plain skull radiographs were normal including views of the sella.

A CT scan revealed a large midfrontal lesion extending predominantly to the left. It was of slightly higher density than brain with effacement of the left frontal horn and striking peritumoral edema. There was a 2 cm left to right shift. After contrast infusion, there was diffuse homogeneous enhancement of the mass. It appeared to arise from the planum sphenoidale extending to the tuberculum sellae. On coronal scan, the mass appeared to extend down to the sphenoid wing just to the left of midline (Fig. 1).

Angiography revealed a left to right shift of the anterior cerebral arteries with draping of the frontopolar and pericallosal arteries left more than right. The tumor was fed by parasitic branches of the left ophthalmic artery (Fig. 2). Selective bilateral external carotid injections demonstrated no filling of the mass, however, digital subtraction angiography suggested a faint tumor blush. The neuroradiologist interpreted the CT and angiographic findings to be most compatible with an atypical planum sphenoidale meningioma.

The patient underwent a large left frontal craniotomy. Upon opening the dura, the tumor was palpable within the frontal lobe but none was evident along the floor of the anterior fossa. Using the operating microscope, the left orbital roof and sphenoid wing were explored. No tumor was found and the left optic nerve and carotid artery were normal. Similarly no tumor could be demonstrated along the olfactory groove, planum sphenoidale or tuberculum sellae medially.

The tumor within the frontal lobe was red-grey, highly vascular, well-encapsulated, and easily separable from the surrounding brain. Frozen section biopsy returned "degenerating meningioma." Ultimately the entire tumor was removed, the brain collapsed into the residual cavity and the case was closed uneventfully.

On histological study the tumor showed a strikingly unusual character. Much of the lesion was fibrotic with islands of well-developed granulomata with varying amounts of central necrosis. A prominent lymphocytic infiltrate surrounded many of the granulomata. The cells within the granuloma included many multinucleated giant cells, some of the Touton type (Fig. 3A). Exclusive of the granulomata, the major cellular component of the tumor consisted of sheets of cells with indistinct borders, granular eosinophilic cytoplasm and vesicular nucleoli (Fig. 3B). No mitoses or atypia were noted in these cells.

Ultrastructural study showed that the granular cells were uniformly engorged with large, multilobulated, pleomorphic, membrane bound inclusions containing lipid and other membranous debris (Fig. 3C). Cellular organelles were not recognized in many of these cells though some showed distorted rough endoplasmic reticulum. Myelin figures were noted in some cells. The cell surfaces showed only sparse basement membrane formation. Assay of the tumor for cytoplasmic receptor proteins for estrogen and progestin revealed high levels of estrogen receptors (40 fM/mg protein).

The neuropathologist interpreted these findings as most compatible with "granular cell myoblastoma" and suggested that the case be reported as a unique manifestation of this unusual tumor.

Postoperatively the patient awoke quickly and was neurologically unchanged. A CT scan one week after surgery revealed residual edema and minor postsurgical hemorrhage but no evidence of tumor. Ten days after surgery his depression had lessened, he was eating well, sleeping well, and taking part in all activities of daily living on the ward. He was oriented in three spheres and could perform simple change calculations. He was discharged home with his family.

Five months postoperatively, the patient was caring for himself at home. He continued to complain of impotence and remained mildly ataxic of gait. A CT scan revealed no recurrence of the previous midfrontal mass. However, 3 cm to the left of midline, just above the edge of the sphenoid wing, there was a small round nodule. Upon reinspection of the original preoperative CT scan, this same nodule was apparent (Fig. 4). At that time it was less than 1 cm in diameter and clearly separate from the main tumor mass. It was evident on only one slice of the scan and was overlooked by both radiologists and surgeons. The nodule did not appear on the initial postoperative scan, presumably obscured by postsurgical hemorrhage and edema.

One year after original surgery, the patient returned with severe headache and a single generalized seizure. CT on this occasion revealed multiple enhancing lesions on both sides of the cerebrum and the cerebellum. He underwent a second craniotomy and biopsy. Pathologic specimens were reviewed by many neuropathologists at several institutions. The unequivocal diagnosis was "noncaseating granuloma compatible with sarcoidosis."

After one month of high-dose corticosteroid therapy, the patient's CT scan revealed no evidence of enhancing lesions and was normal with the exception of postsurgical defects. Shortly thereafter a characteristic sarcoid dermatitis developed, and a chest radiograph revealed development of the characteristic changes seen in pulmonary sarcoidosis.

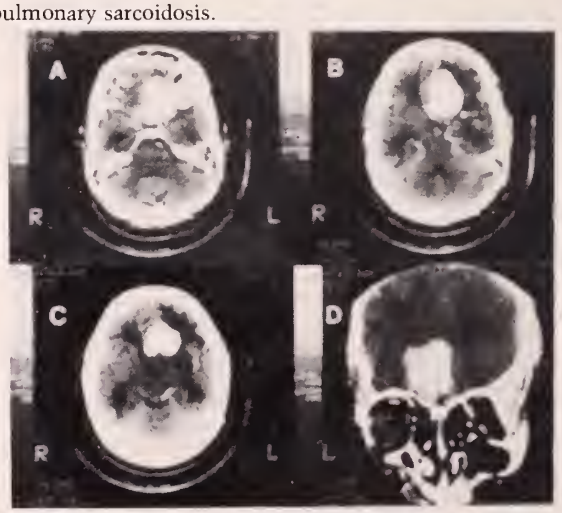


Fig. 1 — Preoperative CT scan (contrast enhanced). (A) Large left midfrontal mass with dense, homogeneous enhancement. Note normal sella. (B) Next consecutive cut revealing normal suprasellar cistern. (C) Next consecutive cut showing diffuse white matter edema throughout left frontal lobe. (D) Coronal scan showing apparent attachment along the left planum sphenoidale.

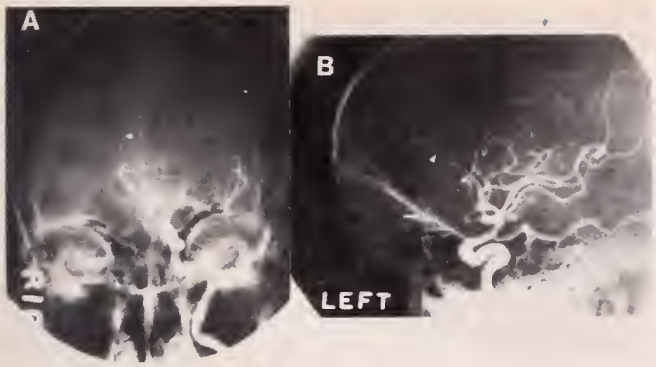


Fig. 2 — Preoperative left internal carotid angiogram. (A) A-P view demonstrating left to right shift of anterior cerebral arteries (arrow). (B) Lateral view showing draping of pericallosal artery (arrowheads). Tumor feeding vessels arise from left ophthalmic artery (arrow).

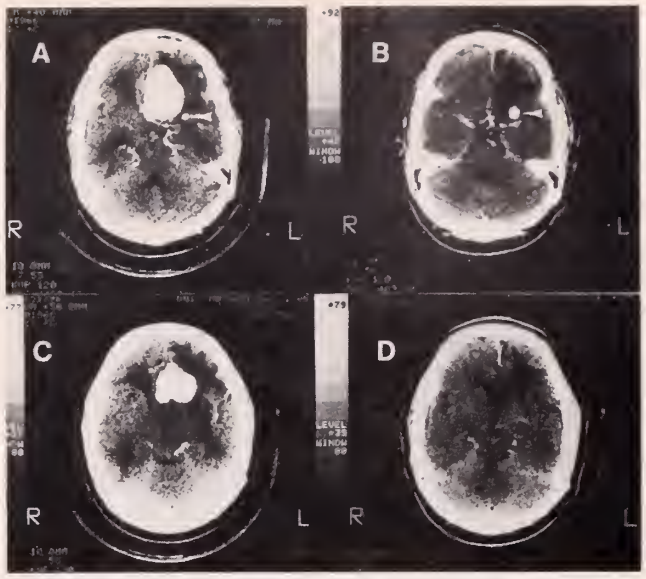


Fig. 4 — Before and after CT scans. Scans on left side of figure (A and C) are from preoperative study (compare Fig. 1). Note 1 cm lesion just over left sphenoid wing (arrowhead in A). Scans on right side of figure (B and D) are from five months after surgery. Note, no recurrence of midfrontal mass. However, mass along the left sphenoid wing has now tripled in size (arrowhead in B).

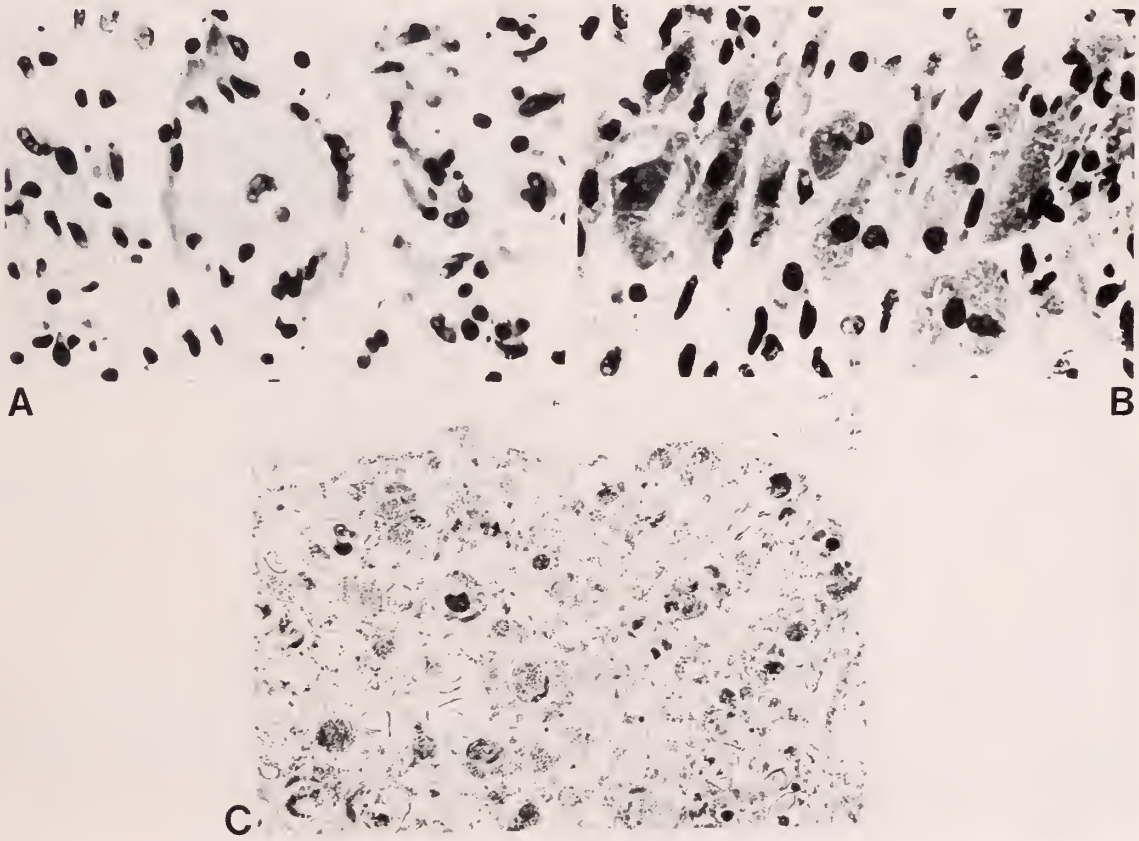


Fig. 3 — (A) High power photomicrograph of granuloma within the tumor tissues showing typical histiocytic proliferation with small oval to round nuclei and indistinct cytoplasmic borders. Note large Touton giant cell in the center of the granuloma with central clearing of the cytoplasm and peripheral orientation of the nuclei. H&E original magnification X400. (B) High power photomicrograph of tumor showing predominant cellular makeup of large granular cells with distinct borders and large vesicular basophilic nuclei with prominent nucleoli. H&E original magnification X400. (C) Electron micrograph of tumor cell cytoplasm demonstrating multiple lysosomal structures including multivesicular bodies, dense bodies, lipid containing vacuoles and membranous debris. Note sparse basement membrane formation at cell surface. Original magnification X15000.

Discussion • In an earlier paper, we suggested that the diagnosis of neurosarcoidosis is a difficult one when the patient has none of the somatic stigmata of the disease.[8] Even the Kviem test and angiotensin converting enzyme are not specific enough to preclude the necessity of biopsy when there is no evidence of pulmonary, ocular, dermal, or glandular disease. This difficulty with diagnosis becomes redoubled when central nervous system sarcoidosis presents with no evidence of chronic meningitis, cranial nerve palsies, hydrocephalus, or significant pituitary axis dysfunction.

There have now been 54 reported cases of intracranial sarcoidosis presenting as mass lesions.[1,2,6,8,11-38] In many of these patients systemic sarcoidosis had already been diagnosed yet the intracranial mass was still confused with other, more common, cerebral lesions.

Half of the cases were reported prior to the advent of the CT scanner.[1,3,6,11-19,27,29,36,37] The angiographic appearance of sarcoid masses is usually indistinguishable from other "avascular" masses and thus may be confused with gliomas, metastases, and abscesses.[35,36] To confuse the issue further, some cases (such as ours) may have a faint angiographic "blush" and thereby may be mistaken for meningiomas.[33]

The other half of the reported cases of intracranial sarcoid masses have been diagnosed by CT scan.[8,20-26,28,30-35,38] Characteristically, cerebral sarcoid masses have a higher density than brain on unenhanced scan and homogeneous moderate or dense enhancement with contrast administration.[2S,3S,38] Unfortunately, meningiomas, metastases, and gliomas may have a similar appearance.

Multiple sarcoid granulomata may have the characteristic appearance of metastases.[30] Frontal or temporal intraparenchymal masses may be indistinguishable from gliomas.[32] Optic nerve sarcoid may have all the radiographic stigmata of optic glioma.[27] Extraaxial sarcoid masses may closely mimic other extraaxial tumors[8,14,15,2S,33] and there have been at least two cases of sarcoid granulomata mistaken for pinealomas![28,34]

This is the 12th reported case of sarcoid granuloma presenting as a subfrontal mass.[1,22,2S,33,36] In all of the previously reported cases, the mass has been near the midline anywhere from the cribiform plate to the suprasellar cistern. Many have been mistaken for meningomas on all preoperative studies.[2S,33] Some of the lesions have involved the dura of the falx or olfactory groove.[23] Others, such as our case, have had no radiographic or surgical evidence of dural involvement. Of the CT-diagnosed cases, none has had evidence of basal cistern or ependymal enhancement with contrast, a finding frequently reported in other cases of neurosarcoidosis.[25,39]

Pathologically, sarcoid masses are composed of characteristic noncaseating granulomata of epithelioid cells, multinucleated giant cells, and mononuclear inflammatory cells. Trombley et al have shown that the electron microscopic features of these cellular components are essentially similar to those of a variety of other granulomatous processes.[40] Hence, like the radiographic findings, the pathologic findings in sarcoid are characteristic and necessary but not specific or sufficient.

Over two thirds of the cases of intracranial sarcoid masses thus far reported have been in males. Our finding of a significant estrogen receptor protein level in this patient's mass is unique. In our review, sex steroid receptor assays have not previously been performed on sarcoid tissue. Nakao et al found serum prolactin levels more than two standard deviations above the mean in 15% of 80 patients with known systemic sarcoid.[41] They believed that this may suggest hypothalamic sarcoid involvement even without other evidence of central nervous system disease. They found that serum prolactin levels frequently normalize after corticosteroid therapy. It is widely agreed that sarcoidosis of the nervous system and elsewhere frequently responds favorably to systemic corticosteroid therapy. Nonetheless, many cases fail to respond and alternative therapeutic avenues would be welcome. If sex steroid receptors can be demonstrated to be frequently present in sarcoid tissue, other avenues may be suggested.

In summary, even with the advent of "fourth generation" CT scanners, magnification-subtraction angiography and the widespread use of the electron microscope in clinical pathology, the diagnosis of neurosarcoidosis may yet be elusive. In patients with known systemic sarcoidosis, the onset of a characteristic neurologic syndrome associated with a characteristic CT appearance may warrant a trial of corticosteroid therapy followed by serial CT monitoring. Nonetheless, in patients with no evidence of systemic sarcoidosis and in those patients with clinically significant intracranial mass lesions, surgery for decompression and biopsy is still necessary.

Acknowledgments

The authors wish to express appreciation to Dr. Lucien Rubinstein of the University of Virginia and to the neuropathology staff of the Armed Forces Institute of Pathology who were instrumental in establishing the final diagnosis in this case.

References

1. Delaney, P.: Neurologic Manifestations in Sarcoidosis: Review of Literature with Report of 23 Cases, Ann. Intern. Med. 87:336-345, 1977.
2. James, D.G. and Sharma, O.P.: Neurological complications of Sarcoidosis, Proc. R. Soc. Med. 60:1169-1174, 1967.
3. Aszkanazy, C.L.: Sarcoidosis of Central Nervous System, J. Neuropathol. Exp. Neurol. 11:392-400, 1952.
4. Day, A.L. and Sypert, G.W.: Spinal Cord Sarcoidosis, Ann. Neurol. 1:79-85, 1977.

5. Jefferson, M : Sarcoidosis of Nervous System, Brain 80: 540-55S, 1957.
6. Silverstein, A.; Feuer, M.M., and Siltzback, L.E.: Neurologic Sarcoidosis, Arch. Neurol. 12:1-11, 1965.
7. Wiederholt, W.C. and Siekert, R.G.: Neurological Manifestations of Sarcoidosis, Neurology (Minneap.) 1S:1147-11S4, 196S.
8. Cahill, D W. and Salcman, M.: Neurosarcoidosis: Review of Rarer Manifestations, Surg. Neurol 15:204-211, 1981.
9. Waxman, J.S. and Sher, J H.: Spectrum of Central Nervous System Sarcoidosis. Clinical and Pathological Study, Mount Sinai J. Med. 46:309-317, 1979.
10. Johns, C.J.: Sarcoidosis, Chap. 216 in Isselbacker, K.J.; Adams, R.D.; Braunwald, E.; Petersdorf, R G., and Wilson, J.D. (eds.). Harrison's Principles of Internal Medicine, New York, McGraw-Hill, 1980, pp. 928-932.
11 Everts, W.H : Sarcoidosis with Brain Tumor, Trans Am. Neurol. Assoc. 72:128-130, 1947.
12. Hook, O.: Sarcoidosis with Involvement of Nervous System. Report of Nine Cases, AMA Arch. Neurol. Psychiat 71:SS4-S7S, 19S4
13. Ross, J.A : Uveoparotid Sarcoidosis with Cerebral Involvement, Br Med. J 2:S93-S96, 19SS.
14. Skillicorn, S.A. and Garrity, R.W : Intracranial Bocck's Sarcoid Tumor Resembling Meningioma, J. Neurosurg. 12:407-413, 19SS.
1S Goodman, S.S and Margulies, M E : Boeck's Sarcoid Simulating Brain Tumor, AMA Arch. Neurol. Psychlat. 81:419-423, 1959.
16. Popper, J.S.; Bingham, W G., and Armstrong, F.S.: Sarcoid Granuloma of Cerebellum, Neurology 10:942-946, 1960.
17. Griggs, R.C.; Markesbury, W.R., and Cardwin, J.J.: Cerebral Mass Due to Sarcoidosis, Neurology 23:981-989, 1973.
18 Norwood, C.W. and Kelly, D.L : Intracranial Sarcoidosis Acting as Mass Lesion, Surg. Neurol. 2:367-372, 1974.
19 Lukin, R R.; Chambers, A.A., and Soleimanpour, M.: Outlet Obstruction of Fourth Ventricle in Sarcoidosis, Neuroradiology 10:65-68, 197S.
20. deTribolet, N and Zander, E : Intracranial Sarcoidosis Presenting Angiographically as Subdural Hematoma, Surg. Neurol. 9:169-171, 1978.
21. Kumpe, D.A.; Rao, C.V G.K.; Garcia, J H., and Heck, A F.: Intracranial Neurosarcoidosis, J. Comput. Assist Tomogr. 3:324-330, 1979.
22. Decker, R.E.; Mardayat, M., Marc, J., and Rasool, A.: Neurosarcoidosis with Computerized Tomographic Visualization and Transphenoidal Excision of Supra Intrasellar Granuloma, J. Neurosurg. 50:814-846, 1979.
23. Post, M.J.D.; Quencer, R.M., and Tabei, S.Z.: CT Demonstration of Sarcoidosis of Optic Nerve, Frontal Lobes, and Falx Cerebri. Case Report and Literature Review, Am. J. Neuroradiol. 3:523-S26, 1982.
24 Chiang, R ; Marshall, M C.; Rosman, P.M.; Hotson, G.; Mannheimer, E., and Wallace, E.Z.: Empty Sella Turcica in Intracranial Sarcoidosis, Arch. Neurol. 41:662-665, 1984
25. Brooks, B.S , El Gammal, T.; Hungerford, G.D.; Acker, J ; Trevor, R.P., and Russell, W : Radiologic Evaluation of Neurosarcoidosis: Role of Computed Tomography, Am J. Neuroradial. 3:513-S21, 1982.
26. McLaurin, E.B. and Harrington, D O : Intracranial Sarcoidosis with Optic Tract and Temporal Lobe Involvement, Am. J. Ophthalmol. 86:656-660, 1978
27. Papo, I.; Beltrami, C.A.; Salvolini, U., and Caruselli, G.: Sarcoidosis Simulating a Glioma of Optic Nerve, Surg. Neurol. 8:353-35S, 1977.
28 Schaefer, M.; Lapras, C.; Thomalske, G ; Gran, H., and Schober, R.: Sarcoidosis of Pineal Gland, J. Neurosurg. 47:630-632, 1977
29. Fine, R D.; Gaylor, J B , and Adams, J.H : Sarcoid Granuloma of Brain, Med J Austral. 50:856-860, 1963.
30. Karnik, A.S.: Nodular Cerebral Sarcoidosis Simulating Metastatic Carcinoma, Arch. Intern. Med. 142:385-386, 1982.
31. Whelan, M A. and Stern, J.: Sarcoidosis Presenting as Posterior Fossa Mass, Surg Neurol. 1S:4SS-4S7, 1980.
32. Powers, W J. and Miller, E.M.: Sarcoidosis Mimicking Glioma Case Report and Review of Intracranial Sarcoid Mass Lesions, Neurology 31:907-910, 1981
33. Lax, F. and Tabaddor, K.: Extraparenchymal Sarcoid Mass, Case Report, Neurosurgery 5.604-606, 1979.
34 Healton, E.B.; Zito, G.; Chanhan, P , and Brust, J C.M : Intracranial Subdural Sarcoid Granuloma, J. Neurosurg. S6:728-731, 1982
3S. Kendall, B E. and Tatler, G L.V : Radiological Findings in Neurosarcoidosis, Br. J Radiol. 51:81-92, 1978.
36. Saltzman, G F.: Roentgenologic Changes in Cerebral Sarcoidosis, Acta. Radiol (Stockh.) S0:235-241, 1958.
37. Smith, L.H.; Farnham, G.F., and Baringer, J.R.: Sarcoidosis of Nervous System, Calif Med. 113:61-64, 1970.
38. Bahr, A L.; Krumholz, A ; Kristt, D , and Hodges, F J 111: Neuroradiological Manifestations of Intracranial Sarcoidosis, Radiology 127:713-717, 1978
39. Morehouse, H and Danziger, A : CT Findings in Intracranial Neurosarcoid, Comput. Tomog 4 267-270, 1980.
40. Trombley, I.K.; Mirra, S.S., and Miles, M.D : Electron Microscopic Study of Central Nervous System Sarcoidosis, Ultrastructural Pathol. 2:257-267, 1981
41 Nakao, K.; Noma, K; Sato, B ; Yano, S.; Yamamura, Y., and Tachibana, T Serum Prolactin Levels in Eight Patients with Sarcoidosis, Eur J Clin Invest. 8:37-40, 1978

● Dr. Cahill, Director of Neurosurgery, University of South Florida, College of Medicine, Box 16, 12901 North 30th Street, Tampa 33612.

A new team of arthritis specialists teams up.

Announcing Florida's Only Arthritis Treatment Center.

A complete team of multidisciplinary specialists, from physicians, nurses, occupational and physical therapists, to social workers, psychologists, pharmacists and nutritionists, will help your patients learn how to cope with their arthritis, lupus, scleroderma or other rheumatic disorders.

Together the team custom designs an individualized program for each patient. Their intensive inpatient program teaches patients how to exercise, avoid joint damage, and cope with the demands of daily living.

Other important members of the treatment team are the patients, their families and their personal physicians. We agree with other successful arthritis treatment centers across the country: teamwork brings results.



Our multidisciplinary treatment program, covers a wide range of activities. From nutritional and pharmaceutical counseling to physical and occupational therapy.

The Parkway Center for Arthritis and Rheumatic Diseases

"New Hope for Independent Living"

AMI Parkway Regional Medical Center

Thriving on Achievement

160 N.W. 170th Street,
North Miami Beach, FL (305) 651-1100

University of Miami School of Medicine — Department of Medicine
Twenty-First Annual Postgraduate Course

"Internal Medicine 1986"

March 2-7, 1986
Sheraton Bal Harbour Hotel — Bal Harbour, Florida

The objective of this course, the twenty-first in its series, is to provide an annual updating of the most useful recent advances in the diagnosis and management of internal medicine disorders as they are encountered by primary care physicians and practicing specialists.

Guest Faculty

Edward Mark Geltman, M.D., Associate Professor of Medicine, Washington University, School of Medicine, St. Louis, Missouri

Richard S. Panush, M.D., Professor of Medicine, University of Florida, College of Medicine, Gainesville, Florida

Oscar D. Ratnoff, M.D., Professor of Medicine, Case Western Reserve University, Cleveland, Ohio

Thomas Spira, M.D., Center for Disease Control, Atlanta, Georgia

Highlights

Symposium on "AIDS": An experienced faculty will discuss the latest developments of the Acquired Immunodeficiency Syndrome.

Meet the Faculty Sessions: Small group conferences in which topics dealing with critical care in internal medicine will be presented, followed by open discussions.

Pictorial Quiz: Our teaching method will cover all fields of internal medicine and will be available throughout the meeting.

Exhibits: Selected Scientific and Technical Exhibits will be on display.

Videotape Symposia: A large TV screen will show selected subjects at specific times.

Hotel Attractions: The Sheraton Bal Harbour is located in the exclusive Bal Harbour section of Miami Beach. The Sheraton Bal Harbour towers above a ten-acre tropical garden with 600 feet of private beach, an olympic-size salt water pool, and a fresh water indoor pool. A golf course and tennis courts are nearby. The Bal Harbour Shopping Center is right across the street.

Social Activities: A varied program will be offered daily for spouses and children.

Accreditation

This program has been reviewed and is acceptable for 33 credit hours in Category I of the Physician's Recognition Award of the American Medical Association and for 33 hours by the American Academy of Family Physicians.

Registration: $500, $300/Physician in Training (Letter from Chief of Service must accompany registration)

For Registration and Information Write: Jose S. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101
Phone: (305) 547-6063

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC.
P.O. BOX 2411, JACKSONVILLE, FL 32203
TELEPHONE 904/356-1571

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

SPECIAL ARTICLE

When should the sick doctor stop caring for patients, and who will make that decision?

Richard J. Feinstein, M.D.

Several years ago, at the age of 40, I broke two metacarpal bones in my right hand while playing basketball. Many of my colleagues were quite eager to tell me how silly I was for playing ball at my age, but I did not really understand the repercussions of that injury to my dominant hand until I showed up at my office the next morning with a short-arm cast. Patients were aghast at my attempt to examine them or even write progress notes in their presence.

Only then did I realize the significance of that injury to my practice, to my earning power and to my patient's trust in me. Most were, I am sure, extremely reluctant to accept care from an obviously imperfect physician, who could possibly inflict harm to them because of a visible disability.

In the 18 years since I graduated from medical school, I have often come to work suffering from a variety of minor ailments. Some, like viral respiratory infections, were infections and potentially contagious to patients. Although I gave thought to the possibility of transmitting a viral infection to my patients, I never allowed those doubts to dissuade me from performing my duties as a physician. My rationale, although never stated in any formal way until now, was a belief that if I felt well enough to work as a physician, then it was the correct decision for everyone involved, including my patients.

The Author
RICHARD J. FEINSTEIN, M.D.
Dr. Feinstein is an Associate Clinical Professor in the Department of Dermatology, University of Miami School of Medicine and a Contributing Editor of The Journal.

From my experiences, and from my observation of others who have become sick or injured, I believe that physicians do not provide good medical care to themselves when they become ill, and they often cannot be relied upon to determine when it is in their patients' or their own best interest to take a leave from their practice because of their own illness.

A vivid example concerns a psychiatrist I know with severe cardiovascular disease, who underwent coronary bypass surgery and resection of a ventricular aneurysm ten years ago. Five years ago he had a stroke while driving his car and ran into a utility pole. He was taken by ambulance to the hospital we utilize and was admitted by a neurologist to the intensive care unit. While a patient on the unit, less than 48 hours after having a stroke, he ordered a unit nurse to bring one of his psychiatric patients to him from her room in another part of the hospital. For some inexplicable reason, the nurse followed the instructions of this aphasic and hemiparetic physician, and brought the psychiatric patient to his bedside for an ill-conceived psychotherapeutic session. The patient, who began to cry uncontrollably on seeing her bedridden and impaired analyst, may have sustained incalcuable harm from that experience.

A recent New York Times article[1] described a hospital in Ogdensburg, New York where a totally blind physician was allowed to perform surgery. The procedures performed were described as those requiring touch rather than sight, but the New York Board of Regents fined the hospital and ordered the physician to refrain from further surgery. He was also ordered to keep his guide dog away from patient care areas in the future.

Physicians are, after all, human beings, and a certain percentage will suffer from blindness,

strokes, and all the other diseases and misfortunes that afflict all people. Unlike most other people, however, physicians possess a license to practice medicine, with its inherent powers and responsibilities, and they are often tempted to serve as their own doctor when they become ill. At times the illness itself, such as chemical addiction, may distort judgement further, making it even more difficult for the sick doctor to seek appropriate care or withdraw from the care of patients.

This problem has taken on potentially greater significance because some physicians may develop AIDS, an infectious disease that could possibly pose a threat to patients. A poignant example occurred three years ago in Miami when a urologist died of AIDS, after having been ill for several years. The Miami Herald alleged in editorials at that time that his treating physician and the hospital where he worked should have forced him to stop practicing when AIDS was first suspected.

His illness and death occurred at the beginning of the AIDS epidemic, and at a time when knowledge about the disease was still scanty. The Herald filed suit against the Dade County Health Department and the hospital to gain access to his medical records and death certificate, allegedly in order to ascertain documentation of his medical history and possible infectivity to patients. The 42-year-old physician had been operating in the hospital until several weeks prior to his demise from pneumonia on July 12, 1983.

The Dade County Medical Association and the County Health Department sought to protect the confidentiality of his illness and death, and his legal rights as a patient. The medical community also sought to shield his wife and two children from lurid media publicity about the diagnosis of AIDS and the possible source of his infection. There was apparently sufficient evidence to believe that he was a homosexual who had acquired the infection through extramarital sexual exposures.

In a recently published article, Sacks describes data on the course of 400 of the deceased urologist's patients, in an apparent attempt to evaluate whether any had developed AIDS from contact with their urologist of two to five years ago.[2] So far, he reports, none has demonstrated clinical evidence of AIDS or AIDS Related Complex, and while this is important in making predictions about the epidemiology of AIDS and its potential for transmission through the routine work of physicians and surgeons, it does not address what I believe is a major ethical question: when should a sick doctor stop caring for patients, and who will make that decision?

Was it known from 1980 until July 12, 1983 when he died, that the urologist's illness, which was accompanied by bouts of opportunistic infections, could not be transmitted to his patients through breaks in the sterile field of the hospital operating room or his office cystoscopy room? If it was known in 1982 or 1983 that AIDS was transmissible from physicians to patients, or if it was uncertain whether it could be transmitted in such a manner or not, who in our city or state was responsible for making the decision to order the sick doctor to stop taking care of patients?

I have been told by a member of the board of medicine in another state that a physician with infectious hepatitis who is practicing obstetrics and gynecology in that state may have already infected several patients. The medical board member recalled with anguish the state board's dilemma in trying to decide what to do about this 43-year-old doctor with chronic active hepatitis. A board decision that he is a threat to patients could terminate his medical practice, while he is still in the prime of his life.

Similarly, important decisions are now almost routinely considered by state medical boards about the fate of physicians whose disease is manifested by psychosis, senility, or an addiction to alcohol or other drugs.

Similarly, important decisions are now almost routinely considered by state medical boards about the fate of physicians whose disease is manifested by psychosis, senility, or an addiction to alcohol or other drugs. While it is true that in the last decade the medical profession has become enlightened about the genetic and biochemical basis for addictive diseases, and has developed improved methods of intervention and therapy, this knowledge does not diminish the possible harm that the addicted and impaired physician can inflict on his unsuspecting patients.

In 1984, while I served as chairman of the Florida Board of Medical Examiners, I received several telephone calls from a central Florida community about an alcoholic obstetrician who was seeking to avoid board-imposed discipline after his impairment was discovered. He had sought treatment at residential facilities in Georgia and Mississippi. It was alleged by the callers and newspaper articles that he had been responsible for the death of two newborns while impaired.

Although a state board of medicine is concerned with an impaired physician's welfare and successful rehabilitation, what are they to do about evidence that an impaired physician may have contributed toward a patient's death while intoxicated?

In another case, an orthopedist who was sued for having negligently casted a young woman's fractured arm had no recollection of anything that had taken place during a four-month period in which he

was almost continuously under the influence of cocaine. He could not remember even seeing the patient or writing in the medical record.

Like many other physicians, I treat patients with AIDS, infectious hepatitis, and other infectious diseases, and I sometimes worry about contracting a disease that could make me ill or terminate my life. I take whatever precautions are possible to minimize the chances of such an event ever taking place. I have disability and life insurance policies to protect me and my family from financial ruin that may occur if I am forced to stop practicing medicine.

I know that I have been given the privilege of taking care of sick humans because my intentions are to try to make them well and to do my best to never make them sick or worse off for having received medical care from me. There may be a time, however, when an illness has so distorted my judgement that I will want to continue to practice when it is detrimental to everyone concerned to do so.

Physicians, like school teachers, food handlers and others, must stop their work when there is any possibility at all that they have become a threat to their clients' safety. It is better, I believe, to err on the side of being more cautious, and it must be remembered that the sick physician cannot be relied upon to make those important decisions on his own.

Physicians, like school teachers, food handlers and others, must stop their work when there is any possibility at all that they have become a threat to their clients' safety.

The treating physician must be the person who determines when the sick doctor is to stop practicing. The sick doctor's office staff, spouse, and children are frequently incapable of making or enforcing such important decisions on their own, but they may be of assistance in helping the treating physician advise or coerce the sick doctor to seek care and stop his practice.

Chemically dependent physicians have a very high level of denial and anxiety, and county and state impaired physicians' committees often use teams of trained intervenors, themselves recovered impaired physicians, to psychologically coerce the sick doctor into seeking care. Several visits are often required before the impaired doctor relents and admits that he needs help. Intervenors often use the threat of license suspension to obtain their results.

Similarly, groups of trained colleagues may be required to visit and talk with doctors who are impaired from other disorders, such as senility, physical disability, or infectious disease. Group action may be necessary when the sick doctor refuses to accept the treating doctor's recommendations to withdraw from patient care. Hospitals or county medical societies may wish to establish committees to deal with the fate of individual doctors who become ill.

Ultimately a state board of medicine should take action to deal with the impaired physician who poses a threat to patients and who refuses to acknowledge his illness and potential harm to patients. Action by the board could result in a loss of the sick doctor's medical license, an important and devastating action to all physicians, even to those who are impaired or seriously ill. Almost all physicians want to retain the dignity of possessing a medical license, and avoiding public dissemination of information about their illness and impairment.

References

1. Brinkley, Joel: Medical Discipline Laws: Confusion Reigns, The New York Times, September 3, 1985, pg 18.
2. Sacks, J : AIDS in a Surgeon, NEJM, Vol. 313, No. 16, Oct 17, 1985, pgs 1017-18.

● Dr. Feinstein, 3661 S. Miami Ave, Miami 33133.

The University of Miami School of Medicine
Department of Medicine
Presents Two Review Courses During 1986

FOR PHYSICIANS WHO ARE PREPARING FOR THE AMERICAN BOARD CERTIFICATION IN INTERNAL MEDICINE

"SECOND REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE"
May 12-16, 1986

A five-day course presenting *selected* topics of the most important areas of Internal Medicine

Thirteenth Annual Review Course for Certification in Internal Medicine

"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"
August 17-30, 1986

This two-week long established course will provide an intensive and *comprehensive* survey of those aspects of Internal Medicine which should be familiar to internists qualified for certification and recertification.

Both courses will be presented at the Key Biscayne Hotel & Villas, Key Biscayne, Florida.

For information: J. Bocles, M.D., Department of Medicine (R760), University of Miami School of Medicine, P.O. Box 016760, Miami, Florida 33101, Telephone: (305) 547-6063.

Marketing of medical services

A decade ago advertising of medical services was considered unethical and illegal. This judgement was abruptly ruled unconstitutional by the United States Supreme Court decision in Bates vs. the State Bar of Arizona in 1977. The decision stated that the prevention of the right to advertise professional services was a violation of freedom of speech, as protected by the first amendment. The original decision specifically involved the legal profession but its ramifications were immediately applied to the other professions. Since 1977 advertising by medical practitioners has increased at a compound rate greater than 50% per year.

Most people equate marketing with advertising; this concept is erroneous because it is too narrow. Advertising constitutes only a single phase of a marketing program. In fact, successful marketing of one's practice need not include advertising at all. In this article, I will briefly examine multiple aspects of medical marketing including advertising.

A sophisticated advertising campaign is probably inappropriate for most physicians because of the expense involved. The costs of individual television or radio commercials vary greatly depending upon the population of the locality in which the physician lives and the medium that is selected. A single, thirty-second, prime-time local TV spot in a moderate-sized city may cost $1200 to $1800. The same television spot on cable TV may cost less than $100. Radio commercials are 30-50% less than TV commercials. Display ads in newspapers and the yellow pages vary from $200 to $10,000. To produce the desired results, advertising needs to be repeated over time. In medium-sized cities, with populations of 100,000 to 250,000 people, an effective advertising campaign costs $25,000 to $150,000 per year. In large metropolitan cities with populations greater than one million people, medical practice advertising can cost $500,000 to $1,000,000 per year. This type of expense cannot be justified by the economics of the solo family physician, who has an overhead of 50% and whose gross income is $150-200,000 per year. To afford a minimal advertising program costing $30,000, the marketing program must generate $60,000 in new revenues just to cover its cost. Such a doctor would have to work for four months just to support the advertising overhead. On the other hand the surgical subspecialists, such as ophthalmologists and plastic surgeons, benefit maximally from advertising. The performance of procedures which command fees of $1,000 to $3,000 each, with little increase in overhead, can rapidly absorb the cost of advertising. In contrast the family physician has to see 40-120 patients, at $25.00 an office visit, to generate the same income as that derived from a single surgical procedure.

Is advertising effective for the individual practitioner? Plastic surgeons and ophthalmologists report a marked increase in their procedural load. Many of the procedures they perform are medically optional and a "need" for these procedures is created by the advertising program. On the other hand physicians in the cognitive specialties report an increase of about 30% in their new patient appointments. So advertising is effective in terms of creating new patients. Whether it is cost-effective is another consideration.

Advertising can be more economical for large group practices because the cost per physician can be diluted enormously. Large groups are similar to hospitals; hospital advertising, in the hands of competent agencies, has profoundly benefitted the profitability of many institutions.

The investment in an advertising program will not always be successful. Success depends upon the careful selection of an agency and an accurate assessment of the practice needs. Agency selection may require six to twelve months of careful investigation. Then the individual physician or group must decide upon the goals of their campaign. They must choose the demographic characteristics of the people they wish to attract. An opthalmologist, who primarily performs cataract surgery, will obviously focus his campaign in media that reach the elderly. Group practices may want to attract a wider audience and employ a more general media approach.

The practitioners must decide if they want to limit themselves to certain social or economic strata. For instance, some doctors only want care for executives and their families; others may want to direct their practices towards the Spanish-American population; and others may want to target industrial companies.

A realistic estimate of the increase in patient volume that will result from advertising should be obtained from several sources.

A realistic estimate of the increase in patient volume that will result from advertising should be obtained from several sources. Then the physician or group of physicians must consider the cost, in terms of time committment and overhead, necessary to satisfy the increase in patient volume. Can the practice serve the projected additional patients while maintaining its current excellence and style, or will expensive alterations of the practice — such as larger offices, more equipment, and additional personnel — be required?

Most members of a partnership or group should be committed to the cost and philosophy of an advertising program, lest friction develop among the members.

The opinions towards advertising of one's professional colleagues must also be measured. If their attitude is negative and the practice, such as that of a general surgeon, relies heavily upon physician referrals, the decision to advertise will stimulate hostility, and may be ruinous to the doctor.

The style of an advertising program needs to be considered. Advertisements modelled to educate the public about a certain medical issue, with a minimum of personal promotion, influence the public more positively than do ads that are designed solely for solicitation.

Despite the tolerance of professional service advertising that was enforced by the Supreme Court and its use by a small minority of physicians, advertising scarifies the professional sensitivities of the overwhelming majority of doctors. However, its effects have slowly and relentlessly encroached upon all of us. HMO's, hospitals, and other forms of corporate medicine budget huge sums for advertising. Some day medical societies or physician groups may need to develop sophistication in the use of advertising to counter the claims and undesirable economic effects of their competitors.

Can a physician successfully market his practice and still eschew the patina of sleaze associated with advertising? Fortunately, the answer is affirmative. Remember that medical marketing is not a recent development. Dr. William Welsh, the first Chairman of Pathology and the first Dean at Johns Hopkins University School of Medicine (who also might be the father of the academic "publish or perish" movement) recognized the importance of marketing in the late nineteenth century. He not only encouraged, but demanded that his faculty publish frequently in order to broadcast the medical and scientific achievements of Hopkins and thereby encourage the use of its physicians and facilities.

Physicians' concepts of "marketing" are too rigid and narrow. Marketing's focus projects beyond advertising and salesmanship. It embraces those methodologies involved in the identification, creation and satisfaction of human desires. Marketing, as so defined and as applied to the individual practitioner, can shun the use of a media campaign while still broadening public recognition and enhancing the image of the doctor. The appropriate target for the physician's marketing campaign is his present patient population. Word of mouth dissemination and elaboration of the wonders of a physician by his patients will attract enough referrals to fill any practice.

The fabric of a good marketing program for individuals is laced with three recurring threads: lucid communication, genuine concern for the patient, and compulsion for excellence. I would like to examine these elements.

Lucid communication is the most essential element but the most difficult quality of an marketing program. We as physicians think we communicate well, but our messages translate opaquely to most listeners. Paul Baehr, Chief of Marketing at Ciba-Geigy Corporation, has examined physician communication skills. He has repeatedly interviewed both the patient and the physician immediately following many consultations, and the interpretations of the contents of an individual session by each participant were discordant in most instances. He concludes that the physicians in his surveys might be verbal but their talent for transferring their thoughts is deficient. Yet patients' uppermost priority in the physician-patient relationship is to understand. Patients know that they cannot always

be cured or helped or even diagnosed. They do not even demand more time from the physician. They, however, need to comprehend the physician's conception of their illness and its prognosis, and they want to be informed of potential complications of both the disease and its treatment.

A bundle of highly-cultivated communication skills remains the most powerful marketing tool of any professional. Our medical office assistants can participate in the communication process. The individuals at the front office, who initially greet the patients as they enter the office or call on the phone, are perhaps the most important links in the communication chain. They must be professional, courteous, and sensitive to the needs of each patient. Medical assistants, working with the physician in the examining room, can assess the patient's understanding of the doctor's message. If the patient's conception is unclear, then the message needs to be repeated. Such repetition bolsters the patient's confidence in the physician and office staff. Communication can be reinforced by the use of brochures or other printed material concerning the disease, its treatment plan or the medication side effects. Brochures can also be employed by describing the physician, his practice style, billing procedures, and appointment practices. Follow-up letters to patients about the results of laboratory tests, procedures, or missed appointments are mandatory.

Communication needs to be aimed at other doctors in the community. Obviously, consultation and follow-up notes should be sent to referring physicians on a timely basis. Also, we need to inform our fellow doctors about what we do. We have to educate our colleagues about the indications and contraindications of procedures we perform, about specialized information we have obtained, and about our special interests. This information can be imparted formally by lectures, or informally in the hallways of the hospital, or over coffee or a meal. Lectures to paramedical personnel, lay groups and to other professionals provide a modestly effective means of increasing public awareness but, as more physicians do this, its impact wanes.

Hawking one's practice at health fairs has been touted as a reasonable marketing ploy, but health fairs are now occupied with so many quasi-scientific and frankly fraudulent exhibitors that such participation may engender a negative aura about the physician.

Genuine concern for the patient is the second element of a successful marketing program. We must identify and attempt to fulfill our patients' needs. In bygone days this meant providing good medical care at a time and place convenient to the physician. Today it means providing excellent care at a time and place dictated by the patient. The successful physician's practice is imbued with exceptional appearance, courtesy and convenience. Sensitivity to the appearance of the staff, their dress, the office itself, and its furnishings is a prerequisite. Cleanliness of walls, hallways and the examining room furniture must be assured.

A bundle of highly-cultivated communication skills remains the most powerful marketing tool of any professional.

Patient convenience must be entertained. Patients want ample parking at the office. They want more convenient office hours. So many people now work that traditional physicians' hours are not appropriate for many. Night, early morning, or weekend appointments will become a necessity. Patients want explanations of the bill and help with insurance forms. They will not tolerate the inconvenience of traveling to several locations for laboratory, x-ray and other diagnostic studies; they want one-stop medical service. If we physicians do not povide it, large retail firms such as Sears Roebuck will.

Promptness in keeping the schedule on time, answering phone calls, and phoning in prescriptions must be assured. Health professionals must be available to patients at all hours. No longer is attention to the patient's medical condition an adequate expression of patient concern. Each of the above items must be incorporated into the culture of the practice.

Excellence is a shop-worn term but, unfortunately, the language lacks other adequate expressions for superiority. In *A Passion For Excellence*, Tom Peters and Nancy Austin described the excellent organization as one which cares for its customers, is constantly innovative, is populated by turned-on employees, and enjoys vibrant leadership.[1]

Excellence implies doing something better than others. This involves superspecialization to some extent by each of us. One general physician may provide a service such as nutritional advice better and cheaper than all other doctors in town and may develop his reputation on this service. A few orthopaedic surgeons now limit their practices solely to surgery of a single joint such as the hip or knee. Ophthalmology is being fractionated into retinal, corneal and lens specialists. As long as a special need exists, someone will succeed if he fulfills that need in a most skillful fashion.

Excellence also implies the recognition and admission of personal limitations. In medicine this admission is reflected by the frequency of referrals; sophisticated patients are well aware of this and develop profound respect for and security with the

physician who seeks the advice of others. Did you ever notice the rapid rate of expansion in the practices of new physicians who routinely use the specialists in their community, and the sluggish growth of the practices of physicians who avoid referrals?

An urgency for excellence must pervade the entire organization. The attitudes of the staff as well as the appearance of the office, personnel, supplies, and stationery must reflect the highest quality. Sloppiness cannot be tolerated and must be expunged. Patients' complaints should be acknowledged, welcomed and addressed properly.

In summary, good marketing for the doctor is applied common sense. Marketing is the practice of the obvious. Fortunately, human nature recognizes but refuses to actuate the obvious and thus the pinnacle of any of life's endeavors is populated by the few.

References

1. Peters, T. and Austin, N.: A Passion for Excellence, The Leadership Difference, Random House, New York, 1985.
2. The opinions expressed in this article are a composite derived from discussions with physicians and other professionals from across the United States who actively use medical marketing and advertising and from public relations and medical marketing specialists.
3. Venkatesan, V.: Medical Marketing, address given to the Volusia County Medical Society, May 11, 1985.

Jacques R. Caldwell, M.D.
Daytona Beach



Among so many once-daily antihypertensives, only one can offer so much...



© 1985 Ayerst Laboratories

Once-daily INDERIDE® LA

The world's leading beta blocker and diuretic—for once-daily convenience without compromise

When selecting other once-daily agents, physicians may have to compromise either their choice of beta blocker or diuretic. With INDERIDE® LA, physicians have the agents most widely prescribed worldwide—INDERAL® and hydrochlorothiazide—with the convenience of once-daily dosage.

24-hour blood pressure control with the broad benefits of INDERAL (propranolol HCl)

The controlled-release delivery system of INDERIDE LA provides 24-hour beta blockade and the broad cardiovascular benefits of INDERAL with a single daily dose. Compliance is enhanced because once-daily administration fits easily into patients' daily routines.

Plus standard-release hydrochlorothiazide, the thiazide of choice for comfortable morning diuresis

Hydrochlorothiazide is the world's most widely prescribed antihypertensive diuretic. When taken in the morning, INDERIDE LA provides comfortable morning diuresis. Each dosage strength of INDERIDE LA contains:

—one of the three most widely prescribed dosage strengths of INDERAL® LA—80 mg, 120 mg, or 160 mg and

—an established, effective daily dose of standard-release hydrochlorothiazide—50 mg

New once-daily

INDERIDE® LA

Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg

Convenience without compromise



80/50 120/50 160/50*

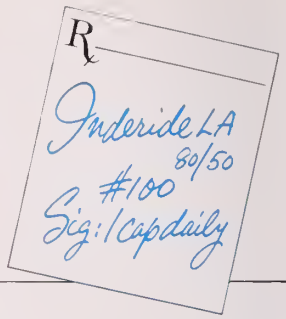
*The appearance of INDERIDE® LA Capsules is a registered trademark of Ayerst Laboratories.

Please see following page for brief summary of prescribing information.

Once-daily INDERIDE® LA

Convenience without compromise
One capsule—Once daily





* The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERIDE® LA Brand of **PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE (Long Acting Capsules)**

No. 455—Each INDERIDE® LA 80/50 Capsule contains

Propranolol hydrochloride (INDERAL® LA)	80 mg
Hydrochlorothiazide	50 mg

No. 457—Each INDERIDE® LA 120/50 Capsule contains

Propranolol hydrochloride (INDERAL® LA)	120 mg
Hydrochlorothiazide	50 mg

No. 459—Each INDERIDE® LA 160/50 Capsule contains

Propranolol hydrochloride (INDERAL® LA)	160 mg
Hydrochlorothiazide	50 mg

INDERIDE LA is indicated in the management of hypertension.

This fixed-combination drug is not indicated for initial therapy of hypertension. If the fixed combination represents the dose titrated to the individual patient's needs, therapy with the fixed combination may be more convenient than with the separate components.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL®):

Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide:

Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL®):

CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced, and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patients should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide:

Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL®):

GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease; elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide:

GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL®):

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency usually of the Raynaud type.

Central Nervous System. Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal. Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System. Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic. Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular. Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity. Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other. Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

5112/985

Ayerst® AYERST LABORATORIES
New York, NY 10017

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy



For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

AN AVIS WIZARD NUMBER. FOR PEOPLE WHO HATE TO WAIT.

It means speedy service, along with special flat rates, for association members.

Avis knows it's frustrating to have to wait for your rental car. That's why we invented the Wizard Number. Once your renting information is on file in our Wizard of Avis computer, you'll be able to reserve an Avis car quickly — at your special association rate.

What's more, with an advance reservation, an Avis Wizard Number entitles you to time-saving services like Avis Express too. At many U.S. airports, it lets you bypass the rental lines and go straight from your plane to the Avis Express facility, where your rental agreement and your car will be waiting. Ask for Avis Express when you reserve your car. All you need is an Avis Wizard Number. (If you don't have one, just complete the application below and mail it in.)

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

Your Avis AWD Number:
A/A 616900

Avis also has many other special services for association members who hate to wait. Ask about them when you call Avis toll free to reserve your car:

1-800-331-1212

AVIS WIZARD NUMBER APPLICATION

Complete and mail to: AVIS, P.O. Box 201, Garden City, NY 11530 Attn: AVIS WIZARD NUMBER DEPARTMENT

F.I. M.I. LAST NAME

MAILING STREET ADDRESS

CITY STATE ZIP

COMPANY NAME

ADDRESS ABOVE IS (Check one)
☐ 1. HOME ADDRESS ☐ 2. COMPANY ADDRESS

DRIVER'S LICENSE # (Include all letters and numbers)

STATE OF ISSUE AVIS AWD # A/A 616900

CHARGE CARD YOU PREFER TO USE:
(Please select only one)
☐ 3. AIR TRAVEL ☐ 4. AMERICAN EXPRESS
☐ 5. DINERS CLUB ☐ 6. VISA
☐ 7. MASTERCARD ☐ 8. CARTE BLANCHE

CARD NUMBER
(Include all letters and numbers)

If you list a credit card but prefer to pay in cash, please check this box: ☐

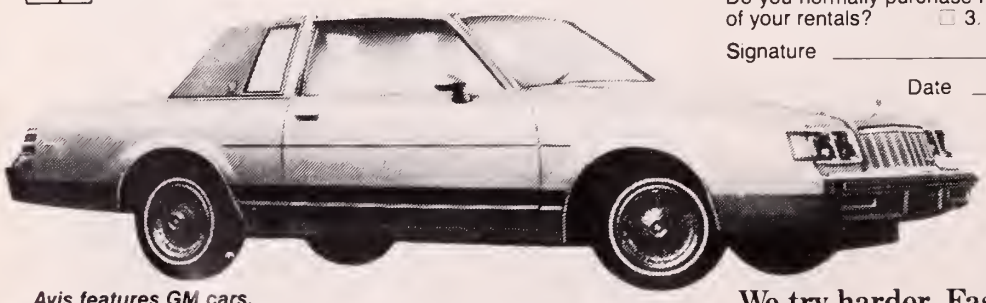
CAR GROUP PREFERENCE: (Please check one box)
☐ 12. COMPACT (Buick Skyhawk or similar)
☐ 13. INTERMEDIATE (Oldsmobile Omega or similar)
☐ 14. FULL SIZE 2-DR (Buick Regal or similar)
☐ 15. FULL SIZE 4-DR (Oldsmobile Cutlass Ciera or similar)

Do you normally purchase the Collision Damage Waiver as part of your rentals? ☐ 1. YES ☐ 2. NO

Do you normally purchase Personal Accident Insurance as part of your rentals? ☐ 3. YES ☐ 4. NO

Signature _____

Date _____



Avis features GM cars. Buick Regal.

We try harder. Faster.™

AVIS®

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. and are subject to change without notice. These rates are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. $3 additional per day on rentals at Newark Airport, NJ, LaGuardia Airport, NY, JFK Airport, NY and all Manhattan, NY locations. Flat rates are nondiscountable. Cars subject to availability and must be returned to rental city or drop-off charge and higher rate will apply. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

1985 Avis Rent A Car System, Inc. Avis®

3/85 Printed in U.S.A.

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 53
- ☐ DEAN'S MESSAGE, 54
- ☐ ENCORES!, 54
- ☐ SCAM OF THE MONTH, 61

☐ NOTES & NEWS

Decreasing trend of both Reye Syndrome and aspirin use supports hypothesis of link between the two: study

A new study which traced the use of medications given to young children with febrile or viral illnesses in Michigan has found a decrease in the incidence of Reye Syndrome — perhaps as a result of decreased aspirin use among children.

Researchers reported that younger parents and parents who had heard of the association between aspirin and the syndrome were more likely to stop giving aspirin. The study, published in the January issue of *Pediatrics*, the journal of the American Academy of Pediatrics (AAP), noted the associated decrease in the incidence of Reye Syndrome tends to support the hypothesis that the use of aspirin increases the risk for the development of the syndrome.

The researchers, from the Michigan Department of Public Health, University of Michigan School of Public Health and the Centers for Disease Control, Atlanta, evaluated the possible changes in the frequency of aspirin use by interviewing 199 families in the Tecumseh, Michigan area. All families interviewed had children under the age of 18.

Based on the reported use of medications for colds or influenza between 1981 and 1983, fewer patients gave aspirin (56% vs. 25%), but acetaminophen use did not change (59% vs. 55%). The study noted that approximately 90% of the parents who chose not to give aspirin for fever also gave medications for colds or influenza that did not contain aspirin. These results suggest that fewer children are receiving aspirin during illnesses that may precede Reye Syndrome, the researchers said.

Reye Syndrome is a disease that can cause brain damage or death and usually follows a child's bout with influenza or chickenpox. It is indicated by vomiting and lethargy, which may develop into delirium and a coma. Death occurs in 20% to 30% of the cases and there is permanent brain damage in many of the others, the Government has reported.

The decrease in the number of cases of Reye Syndrome reported yearly to the Michigan Department of Public Health since 1980 has also been seen in the other states and nationwide, the researchers continued. "This change most likely resulted from the widespread publicity about the association between aspirin and Reye Syndrome. In 1983, parents (in the study) named television, newspapers, schools, health-care providers and neighbors or friends (53%, 49, 11, 10 and 7, respectively) as sources of information on Reye Syndrome," the authors wrote.

In addition, the study cited that since 1980 there has been a decrease nationally in the number of cases of Reye Syndrome reported in children younger than 10 years of age. However, that does not hold true for the number of cases in children over 10, which remained constant. "Perhaps parents are giving aspirin to their younger children less often, but their older children are self-medicating and have, therefore, not changed their pattern of aspirin use," the researchers concluded.

The American Academy of Pediatrics is an organization of 28,000 pediatricians dedicated to the health, safety and well-being of infants, children and adolescents in North, Central and South America.

JCAH publishes the 1986 Accreditation Manual for Hospitals

The Joint Commission on Accreditation of Hospitals (JCAH) has announced publication of the 1986 edition of the *Accreditation Manual for Hospitals*. The *Manual*, effective for accreditation decision purposes on January 1, 1986 has been completely revised and placed in an outline format. A numbering system for all standards and required characteristics and a new five-point rating scale make the *Accreditation Manual for Hospitals* an excellent self-assessment tool for hospitals and will allow surveyors to use the *Manual* as the survey report form. Because the *Manual* will serve as a self-assessment tool, JCAH will discontinue publication of the *Hospital Survey Profile*. The *Manual* also includes important new and revised chapters: an entirely new "Rehabilitation Services" chapter, governing standards pertinent to multihospital systems and corporately structured hospitals, and revisions to the "Medical Staff" chapter.

To order the 1986 *Accreditation Manual for Hospitals*, send $50 per copy to: Cashier, JCAH, 875 North Michigan Avenue, Chicago, Illinois 60611. For further information regarding this or any JCAH publication, contact Customer Service at JCAH, (312) 642-6061.

AIDS brochure available through hospital association

The South Florida Hospital Association has prepared a question and answer brochure on Acquired Immune Deficiency Syndrome, AIDS. Free to the community, *Straight Talk About AIDS* covers definitions, exposure, risk groups, symptoms and treatment of this controversial disease.

"Everyday the community is bombarded with rumors mixed with fact. This confusion only leads to unnecessary anxiety. We developed this pamphlet to help allay fears and provide straightforward answers to the questions most often asked about AIDS," says George Berch, president of the Miami-based trade group, which represents some 50-member hospitals in Dade, Broward and Monroe countries.

This brochure explains the attack upon the body's natural immune system, and outlines the symptoms and testing procedures to determine the presence of HTLV-III, the AIDS virus. It also identifies high risk practices and what can be done to minimize the risk of contracting the disease.

To receive a free copy of *Straight Talk About Aids*, write to the South Florida Hospital Association, 8245 N.W. 53rd Street, Suite 200, Miami, Florida 33166-4609, or call 591-8020 in Dade County and 522-3433 in Broward County.

DEAN'S MESSAGE

Our younger colleagues

A remarkable increase of interest in organized medicine among the nation's medical students is occurring. The vicissitudes of the medical atmospheric conditions have precipitated this interest. Matters such as projected physician surplus, alternative delivery systems, U.S. citizen foreign medical students, increasing competition for graduate medical education positions, decreased funding for residency positions, and levels of reimbursement for patient care are of great concern among students.

The Medical Student Section of American Medical Association is growing. At each of the two yearly meetings of the House of Delegates, there are several hundred students present. These young people take a very active role in the deliberations of the Reference Committees and House of Delegates' affairs. At the Association of American Medical Colleges, students have played a key role for years. The American Medical Student Association is a growing student group. The American Women's Medical Association has taken a very active interest in women students and has made them an important group within that organization. The American Academy of Family Practice is known for its medical student programs.

It is clear that the students' involvement in organized medicine today will benefit the profession tomorrow. The infectious nature of their involvement should stimulate each member of the Florida Medical Association to become active. The organization is as effective as its individual members. The challenges and opportunities confronting us are great and time is short.

This year *The Journal of the Florida Medical Association* will include in this section an editorial by a student from each of the three medical schools in Florida. The readership will be positively impressed by the maturity, clarity of thought, and the talents of our younger colleagues.

". . .the flower of youth, wherein is the fullness of strength. . ."

Homer (c.850 B.C.)

William B. Deal, M.D.
Dean and Associate Vice President for Clinical Affairs
College of Medicine
University of Florida

ENCORES!

Points of view: technology and the experimental boundary

The rise of health care technology to a high level of professional and public visibility is one of the most important landmarks of the 20th century. It has been accompanied by a spate of problems that go beyond traditional concerns over technical performance to encompass crucial ethical dilemmas.

Such concerns come together in the question of when it is appropriate to move therapy from the laboratory to an experimental test in a human subject. This issue is important because, in recent times, human beings have increasingly become the source of experimental data, and the development of medical technology hinges on such trials.

A critical consideration is determining when all that might be learned in the laboratory has been learned in it. According to the Nuremberg Code, written in response to the terrible abuses of human beings during experiments carried out in the course

of World War II, the human test is warranted when there is an expectation that its results will be fruitful, when the knowledge sought cannot be gained by other means of investigation, and when the researchers take care that no random or unnecessary features are part of the protocol. The design of the experiment should reflect the results of animal investigations as well as knowledge of the natural history of the disorder, and the investigators themselves must believe, and be able to justify to others, that the anticipated results justify the performance of the experiment.

In the current controversy surrounding implantation of the artificial heart, for example, and important issue is whether the investigators have learned enough about the problems of power supply, clotting produced by the meeting of artificial surfaces and blood, and many other variables to warrant use of the device in a human subject. One passage of the consent form[1] developed for Barney Clark, the first recipient of the heart, states several of the justifications for trial of the device:

> The University of Utah has had extensive experience with living animals implanted with a similar model of artificial heart as will be used in my case. The present human model has had only limited testing in these animals. However, the device to be used is the most refined and advanced model which is available for use in a human. To date the longest an animal (a calf) has lived with an aritificial heart is nine months. Most animals live for about three months in experiments designed to test long-term effects of heart implantation. The poor hygiene of animals makes it very difficult to keep them clean and most die from infections caused by bacteria entering around the drive tubes or other tubes used to monitor the function of the heart. Other common causes of death in these animals are: infected blood obtained from packing houses which is used to transfuse them, insufficient blood volume coming from the heart as the calves grow, and the artificial heart developing mechanical problems. While these complications reflect problems which may be unique to animal experimentation, they also provide additional warnings of risk.

In the American experience with the artificial heart, two of the subjects have died, two subjects remain seriously ill, and several major problems — most notably the blood-clotting problem — persist, requiring more scientific knowledge than we currently have. Given these facts, should more research have been done in the laboratory before human trials were initiated?

A second requirement of human experimentation is that the research question be clearly defined, so that a clear result may emerge from the procedure. To return to the example of the artificial heart, how should success be defined? Even the innovators of the device and the procedure were unsure of the definition months after Barney Clark, who had lived 112 days with the artificial heart, died.

During a discussion at an academic conference on the artificial heart, the principal surgeon, Dr. William DeVries, was asked by Dr. Eric Cassell, a clinician and ethicist at Cornell University Medical College, about the criteria that the Utah team had used to measure success in the Barney Clark case.

Dr. Cassell asked, "What if he had lived a year?"

> DeVries replied that the entire team had discussed that question, and the definitions of success had ranged from coming off the operating table alive to surviving several years. DeVries himself would not have been satisfied with merely getting his patient off the table. "You can do that with a cadaver," he said. He had hoped to make Clark well enough to go home. Reiterating that the main goal was therapy, DeVries said that if Barney Clark had no regrets, then the procedure was a success. Social worker Peg Miller added that Mrs. Clark regarded the experiment as a "partial success," and Jarvik said that from the researchers' standpoint, it would have been "impossible" not to learn something. But, like DeVries, he felt that for the procedure to be called a success, "the patient must say it was worth it."[2]

A third general issue concerning the transition of research from a laboratory to a clinical setting is the consent of the subject. This issue has been one of the dominant topics of discourse since 1945 in the ethics of experimental and therapeutic medicine. It is raised in the first principle of the Nuremberg Code, which asserts that the human subject must have the legal capacity to give consent, meaning that he or she must have reached the age defined by society as that at which his or her parents are no longer guardians. Further, the subject should be in a situation in which a choice can be made freely, without the influence of elements of constraint or coercion.

Essentially restrictive environments, such as prisons, or certain relationships — such as teacher-student or employer-employee relationships — in which one has excessive power over the other threaten the consent process. Can prisoners make a choice not affected by duress or overreaching elements inherent in their environment? Can the con-

sent of a student to the request of a teacher, who is also an investigator, to participate in a study always be free of coercive elements? Such questions warn us that we must carefully consider whether truly voluntary consent may be obtained from persons in vulnerable populations and restrictive environments. If it cannot be, experiments should not be undertaken in such populations.

The ability of potential research subjects to understand the risks and benefits to which an experiment exposes them and the completeness of disclosure of these contingencies by investigators are other important elements of the consent process outlined in the Nuremberg Code. Thus the mental competence of the subject and the clarity with which investigators explain an experiment are crucial factors in determining the propriety of the consent procedure. In the two decades following publication of the Nuremberg Code, incidents caused the medical world and the public to question the care with which these ethical standards were being observed. Accordingly, on February 8, 1966, the Surgeon General of the United States issued a directive requiring all medical institutions conducting human research that were recipients of federal monies (that is, virtually all institutions conducting human research) to convene human studies committees. These committees, now called institutional review boards, were charged with ensuring that consent procedures be appropriate and that experimental design minimize potential harm to human subjects.

The issue of transferring investigations from the laboratory to the clinical setting involves more variables than space allows me to consider in this brief comment. However, it is clear that those who innovate must consider more critically the circumstances under which it is proper to cross this boundary.

Stanley J. Reiser

References

1. Shaw W., ed., After Barney Clark: Reflection on the Utah Artificial Heart Program, Austin: University of Texas Press, 1985:198.
2. Ibid., 48.

Reprinted with permission from *Health Care Instrumentation*, Volume 1, Number 2, 1985.

Business barracudas feeding on doctors

Take-over fever has taken over medicine, and physicians are the victims.

Everyone knows that "old-time medicine" was too good to last. The days when doctors and hospitals split the pie between themselves are gone.

When the nation's health care bill was relatively small, corporate America figured it would leave us alone. But now that more than $1 billion a day is spent on health care, American businessmen have decided to get in on the action. The end result is to make corporations and businessmen rich, while reducing physicians to the level of the common worker.

Over the last 10 years a dramatic restructuring of our nation's health care system has taken place. Not being content to simply own and manage hospitals, huge corporations are buying hospitals, insurance companies, suppliers and even health care providers.

Following closely on the heels of the major companies have come a vast number of individuals and groups anxious to grab their share. These commercial barracudas have appeared out of nowhere, passing themselves off as friends of the doctor, more than eager to help start (for a fee, percentage or stock of course) new forms of health care in the attempt to control health care costs.

I am reasonably sure that if one were to add the amount spent for health care in our trim, new, more efficient system, to the amount paid for administration, entrepreneur's salaries, legal and consultant fees created by these new systems, the total would be greater then was spent on our bloated, inefficient and wasteful health care system of a few years ago.

The difference is that the amount "saved" through lower health care costs has been taken from doctors and hospitals and put in the businessmen's pockets. Of course, the public sees this as entirely fair because it praises financial success in business and criticizes financial success in medicine.

When the vice president in charge of whatever for a fledgling health care system drives up in his new Mercedes (a company car of course), he is the envy of his business colleagues and honored as an outstanding and successful community leader. For shame the doctor who drives up in his Mercedes, because his income is derived, it is assumed, by preying on the poor and the infirm.

I cannot count the number of presentations by businessmen, insurance salesmen, computer programmers and the like who have promised to reorganize the way I deliver health care. Some of these people even have the gall to ask me to pay a fee to join their group/organization for the privilege of

getting in on the ground floor of their grand scheme.

From a profit standpoint, it makes great sense to sign up a bunch of doctors at $1,000 to $2,000 each and then try to peddle the scheme to the world. If the plan does not work, the barracudas are no worse off, having drawn a salary and enjoyed the usual business perks.

If, on the other hand, the gamble pays off, some people stand to make a great deal of money. Large sums can be made by the plan owners by selling their company to another one. We are caught up in the Wall Street madness where income is received, although not earned, through the transfer of paper.

And where do physicians stand during all this turmoil? If any of them happen to be the owners of the corporation, they might have a financial windfall. Those that are not so lucky have been relegated to the role of a common laborer, working and generating income for a company that may not have the slightest interest in the practice of medicine, let alone in quality medical care.

The noble profession of medicine which stood alone and unchallenged for so many decades is becoming a labor force whose task is to generate income for the company store, controlled by nonphysicians.

Doctors are notoriously their own enemies, and paranoia is our own special poison. It is time we let the business world know that we are not going to join everyone's get-rich-quick scheme for medicine. We are not fair game for yesterday's insurance salesman/today's health care executive.

Certainly reputable companies with proven track records are out there and may have something to offer, but most of the people we are seeing today will be gone as fast as they appeared.

We can control our own destiny. The big question is, will we?

Lee A. Fischer, M.D.
West Palm Beach

Reprinted with permission from *South Florida Medical Review*, November 19, 1985, pg. 60.

The search for available insurance: where is it?

Turn to the financial pages of practically any newspaper these days and you are likely to find the latest chapter in an ongoing saga called "Why Can't Our Businesses Get Insurance Coverage?"

While the headlines may seem commonplace, the situation they describe is deadly serious for many. More and more taverns, for example, have difficulty finding coverage required by laws that hold them responsible for a drunken patron's traffic accident, while day-care centers are having difficulty finding coverage because of insurers' fears of excessively high jury awards in child sexual-abuse allegations.

Hundreds of other individuals and businesses — including municipalities, corporate directors, physicians, laundromat operators, long-haul truckers, accountants, and companies that deal with asbestos or hazardous waste — all have the same complaint: They cannot afford or are having difficulty finding liability insurance. And without insurance, they often cannot stay in business.

The property and casualty insurance industry is deeply concerned about the effect this problem is having. According to insurance groups, their member companies, and state regulatory agencies, availability and affordability of insurance is a problem in certain liability lines in many states. But the problem may not be so much availability, but rather affordability. In a word, the price of coverage is going up, and the reasons why may be a bitter pill for many to swallow.

Assessing the risk • The current rash of litigation and seemingly excessive jury awards are among the main answers insurers give when asked why it is difficult for businesses to find coverage. Insurers say they cannot be sure how a court will interpret insurance contracts; therefore, their means of calculating the risk is impaired. So insurers are raising prices and getting out of certain markets in self-defense.

Last June, insurers told a group of insurance commissioners assembled in Chicago they depend on their ability to estimate the likelihood of claims and the size of losses when offering coverage. Insurers cannot do that unless they know what their obligations are at the time they issue the contract. They cited several recent court rulings that ordered insurers to pay liabilities that insurers clearly intended to exclude from contracts. The insurers said such judgments, coupled with rapidly growing multi-million-dollar court awards, make it impossible to estimate kinds and amounts of claims they will be paying in the future. Unable to estimate exposures, insurers are getting out of the market.

The outcries of many insurers were summed up recently by the Insurance Services Office (ISO): "Many types of damages that were never even remotely contemplated being written are now being paid." The claims seem to be well founded as newpaper headlines carry almost daily accounts of multi-million-dollar court-ordered damage awards

and defense costs in cases such as asbestosis, Agent Orange, and the Dalkon Shield.

One change insurers are currently advocating involves the potential liability period covered by policies. In recent years, courts have forced insurers to pay current claims for injuries that occurred decades ago. Under new proposals, such as ISO's "claims-made" policy, a current insurer would pay for claims made while its policy was in effect, regardless of who the insurer was during the injury period. Insurers say their rates were never intended to cover damage claims decades into the future and the new "claims-made" policy will give them a better idea of what their future risks would be.

The cost of defending claims in court is another area where insurers are seeking change. Defense costs for general liability claims have risen a hundredfold since the 1950s to nearly $2 billion a year. Under new proposals, legal costs would be included in the aggregate limits of the policy. Businesses argue that defense costs typically amount to 35 to 50 percent of coverage limits, and the new proposal would mean half of their liability protection would be eaten up.

ISO officials counter with a recent case where an insurer spent $369,000 to defend a claim where the policy limit was $100,000. The court required that, under the insurers duty to provide a good-faith defense, insurers must defend the claim, whatever the cost. ISO spokesmen say the current system is almost a free lunch for business in lawsuits, with no incentive for the policyholder to cut defense costs. With defense costs contained within policy limits and subject to a deductible amount, says ISO, there would be incentive.

The growing tendency to sue • Are Americans more quick to sue? Are we now a more litigious society? Do we have a population that believes it is at the mercy of big business, big money, and big government; and, given the opportunity, does the common citizen feel he or she is entitled to milk the system through the courts? *Forbes* magazine cites the 1984 average product liability award as $1.07 million and the average medical malpractice award as $950,000 and reports Americans now look on a civil suit as a kind of lottery to be played whenever they can. The magazine reports there was one private civil lawsuit filed for every 15 Americans during 1984.

Caught in the middle is the insurance industry, which many see as a "Deep Pocket" litigant — with unlimited resources to richly compensate individuals for any degree of injury. The result is what many analysts call "a suing society." Juries are also caught up in the trend, and what was a once-rare million-dollar award is now a common occurence.

Many feel the current trend to sue, the "Deep Pocket Theory," and the sizable award verdicts demonstrate that courts find ability to pay more important than degree of negligence. And insurance companies and governments are perceived to have the ability.

Is the "Deep Pocket Theory" just so much rhetoric? Not according to a recent Rand Corporation study of jury awards in damage cases. The study looked at 9,000 cases in the Cook County (Chicago) area where severe injuries resulted in permanent disability. When the defendant was a corporation, the median award was $161,000; when the government was the defendant, the median award was $98,000; and when the defendant was an individual, the median was $37,000.

Cautious reinsurers • Uncertainty in the U.S. legal system is also affecting reinsurers — those who underwrite insurance companies and assume portions of risk on a policy. Lloyds of London may lead the exodus of reinsurance brokers away from the U.S. market unless, it declares, something is done about the American civil justice system.

At a mid-summer meeting in Chicago, Lloyds broker Gerald Wakefield spoke on the unpredictability of American courts and ability of U.S. judges to reinterpret coverages years after a policy is contracted: "Lloyds underwriters lost a great deal of money," Wakefield declared, "not because of stupidity or mismanagement, but because of the uncertainty of the rules.

"It is not Lloyd's business to tell you how to conduct your affairs," Wakefield continued. "It is our business to tell you how we will conduct our affairs. Lloyds is saying that unless there is a change, we will not enter into contracts with you and won't accept your risks.

Municipal woes • Court decisions in the last few years have also proven you can fight city hall — and be handsomely rewarded. Many municipalities are finding that sovereign immunity — protection from lawsuit in the performance of governmental functions — is no longer a defense as they appear in court on behalf of their police and fire departments, schools, parks, playgrounds, public works, transportation systems, and so on. The new types and sheer numbers of municipal lawsuits, unheard of a decade ago, have resulted in dramatic insurance rate increases for many cities, where coverage is still available.

Since the mid-1970s, courts have gradually eroded the doctrine of sovereign immunity and are expanding their new-found freedom of interpretation

in many municipal liability cases. They are reading into insurance contracts many things that were unintended. Pollution liability is a current case in point. Publications such as *Forbes*, *USA Today*, and *Risk Management* all point to the now famous Jackson Township case where a policy written to cover sudden, accidental spills was broadened by a court to include coverage for pollution from a municipal landfill that had occurred over a period of years.

The court awards in these types of cases have also increased dramatically. A 1982 survey of 937 cities recorded the top award sought as $40 million. In 1985, a survey of 1,244 cities recorded an average claim in the $100 million to $200 million range. In addition, the number of lawsuits filed against public officials has doubled since 1982.

Liquor liability • Another group experiencing high policy cancellations and dramatic rate increases is the retail liquor business — those who are required to have liquor liability coverages. The present outcry to get drunk drivers off the road has added to court burdens as many victims look to the civil justice system for retribution. Those citizens are bringing lawsuits, not only against the drunken driver but also, through "Dram Shop Laws," against the establishment or the party host that served the liquor.

Many of the nation's 37 state "Dram Shop Laws," on the books since the repeal of Prohibition, were seldom used. According to Mothers Against Drunk Drivers (MADD), the number of Dram-Shop cases has tripled in the last three years. MADD reports the typical damage award is over $100,000, but cites some settlements as high as several million dollars. Many of the suits are settled out of court, yielding no accurate figures on cases filed. However, the Prevention Research Center in California estimates between 1,000 and 3,000 cases have been filed in the last 12 months.

In a few states, the claims have been so numerous, the jury awards so substantial, and the resulting risks so great that insurance companies simply cannot afford to offer liability coverage to certain businesses.

But bars, taverns, and restaurants are not the only places where people drink. Realizing that, several states including Indiana, Iowa, and New Jersey extend dram-shop laws to social hosts. In a recent landmark New Jersey case, an award of nearly $200,000 was paid jointly by the driver, his auto insurer, and the party host's homeowners' insurer.

As in many cases, insurers argue the policies that tavern and restaurant owners buy were not designed nor priced with either the current legal interpretations nor the number of excessive court verdicts in mind. After a few years of experience with the courts, insurers thought they understood what kinds of actions to expect from the courts. That is no longer true and insurers are raising their rates to provide coverage under the new liquor liability.

Can insurance, as a "risk spreading mechanism," afford to pay for the outrage society feels toward drunk drivers? A few states, aware of the multimillion-dollar verdicts being rendered and aware of the present-day costs of insurance, are working to limit liabilities by placing ceilings or "caps" on the damages that can be awarded in such suits in an effort to avoid an availability/affordability crunch. In Connecticut the ceiling is $50,000. Other states have passed legislation for a joint underwriting association (JUA) that will provide its own insurance to restaurants and taverns. A JUA is state-ordered association of insurers formed to provide a particular type of insurance not available in the voluntary marketplace. Specific insurance companies issue policies at a set rate and pay claims, but the ultimate costs are borne by all companies writing insurance in that state. A Massachusetts JUA carries a liability limit of $500,000 per individual. Insurers question whether in these times of monumental awards juries will see the half-million dollars as an award goal rather than a limit.

Rural arson: more excess risk • Agents in several southeastern states also say they are having trouble finding fire insurance coverages for customers with rural structures, referred to as Class 9 and 10 fire risks. Insurers say coverages are available but add that these are often farm structures with typically low value — usually $25,000 to $30,000 — and their distance from water sources and fire departments make them a questionable risk with most fires resulting in total losses.

In answer to agent's demands in Tennessee, a marketing assistance program (MAP) was set up in August through the state insurance commissioner's office — complete with a toll-free telephone number. Although insurers argued that no availability problem existed in the state, 40 of the state's 49 insurance companies voluntarily joined the MAP. The farmers would have to prove that the property was well maintained, was used as a principle residence, was financially stable, and had no adverse loss history. Two months after the Tennessee program started there have been 45 applications for coverage through the MAP. Insurers and insurance commissioners alike are reserving comment on the low number of applications. Meanwhile MAPs are presently being set up or at least considered in Mississippi, North Carolina, Florida, Oklahoma, West Virginia, and Arkansas.

Day care centers • With reinsurers reluctant to work with carriers and carriers unable to tell what future losses might be, it becomes clearer why day care centers may have trouble finding the liability coverages required by law in 24 states.

The problems day care center operators are having buying liability insurance are indicative of the larger availability-affordability issue. Splashy newspaper headlines reporting instances of sexual abuse of children may be the reason one or two insurers are hesitant to cover the facilities. But a more significant reason is that no figures really exist for liability experience in the smaller family-home types of day care facilities. And since America is the only country in the world with no organized system of child care services, there is no effective regulation nor standardized rules.

With no certification or standards, insurers can neither assess the risk nor price the product. Considering the unpredictability of today's court decisions, many insurers feel they are taking their financial life in their hands with this line of liability coverage. Hence, carriers are limiting coverage and raising rates amidst outcries from day care center owners and operators.

Common denominators • The Alliance of American Insurers identifies four common denominators in the availabilty-affordability issue:

- The increasing costs of a civil justice system that reinterprets insurance policy language to assure that every injury is compensated regardless of who is at fault;
- Multi-million-dollar jury awards;
- Lack of performance, financial responsibility, and licensing standards for certain occupations that are highly susceptible to lawsuit; and,
- The poor financial condition of the insurance industry itself. (See following article, "Where the dollars are — or were.")

As a result, insurers have had to draw back from certain lines of insurance where losses would be too far in excess of premiums.

According to Alliance of American Insurers President Franklin W. Nutter, "Reinterpretation of policy language by courts and multi-million-dollar awards have encouraged a hysteria of lawsuits. These factors have created a legal morass in the court system, have filled the court schedules, and have driven defense costs beyond the ability of insurers to cover.

"Insurers, who must answer for their actions to stockholders, policyholders, and regulators, have acted to assure their solvency and their ability to provide for the insurance needs of the greatest number of policyholders.

"The property and casualty insurance business, both individually and through trade associations, is working with regulators and consumers to develop solutions to the issues of affordability and availability. In some lines of insurance, the problem will be temporary until economic conditions improve or occupational standards are adopted," said Nutter. "For other lines, however, the situation will only be resolved when viable civil justice reform is enacted that provides more certainty to the amount of risk. The insurance industry can only provide coverage when it can determine with some certainty the extent of its future liabilities. Asking to do otherwise ignores both its function and responsibilities in the American economy."

Where the dollars are — or were

The present problems of availability and affordability cannot be fully explained from an insurance perspective without an appreciation of the current financial condition of the property-casualty insurance business. In 1984, the insurance industry experienced its worst year ever. According to ISO senior vice president Mavis A. Walters, underwriting losses for the industry have reached $55 billion since 1979. Walters, speaking before a U.S. House of Representatives Subcommittee hearing on liability insurance, said that $21 billion of that total was in 1984 alone. The combined ratio (the comparison of incurred losses, expenses and commissions to earned premium) reached 118 percent for 1984 for all lines of business. That means it cost the industry $118 for each $100 of premium it brought in.

Although underwriting results have declined since 1979, investment income has grown. However, says Walters, the average annual investment income growth of $1.7 billion (money the insurance industry makes through investment of premium dollars) does not match the $3 billion annual growth of underwriting losses. In 1984, investment income grew ten percent but underwriting losses grew by 60%, producing a pre-tax operating losses (losses less investment income) of $3.8 billion. "Clearly, losses of that magnitude cannot be sustained without adverse consequences," Walters said.

The end result of the dismal financial conditions of 1984 is a decline of nearly $2 billion in policyholder surplus — a measure of an insurance company's ability to stand behind its policies with uncommitted funds. That ability is now very limited, says an ISO study done in early 1986, entitled *The Coming Capacity Shortage*. ISO estimates that ability of property-casualty insurers to insure will fall short of demand over the next three years. Industry spokespeople estimate that billions of dollars

worth of insurance will not be covered. In other words, the demand for insurance will exceed the supply.

Even though insurance companies are now compensating by raising prices and getting out of types of business they know invite devastating claims, their losses continue to mount. According to ISO, there is still a sizable gap between the premium dollars coming into insurance companies and the claim losses those companies are paying out. The business insurance consumer has been getting a bargain on premium for the past six years, says ISO. But now the sale is over, and these risky new businesses who are unable to pass on price increases to their cutomers, may become victims of their own excessive risk potential.

Reprinted with permission from the *Journal of American Insurance*/Fourth Quarter, 1985, pg. 1-5.

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"I can't sleep, it's my job scam"

Recently, investigators in the Kansas City area interviewed numerous physicians concerning the prescribing of SECONAL, NEMBUTAL, TUINAL and QUAALUDE for a group of patients apparently living at a single address. Ten individuals were identified, (three married couples and four single men), all alleged to be working at jobs on the evening shift at various car assembly plants in the area.

Investigators located prescriptions for these "Professional Patients" in a four county area. Four of these individuals were seeing ten physicians at the same time and telling each physician the same story.

While attempting to verify the places of employment for these individuals it was learned, (from the local police department) that several of the professional patients were apparently major drug dealers and that they were not employed at the car assembly plants. In fact, they were not employed at all, but were obtaining Welfare and Medicaid payments.

Caution • Physicians should make certain who they are treating by requesting positive identification and by verifying employment by contacting the employer. Physicians should also be cautious of referrals from one or a small group of patients who are receiving Controlled Drugs from that physician, especially if all of the referrals are for the same treatment and drugs.



You don't have to move mountains to make a difference on this earth. Or be a Michelangelo to leave your mark on it.

Leaving even the smallest legacy to the American Cancer Society can help change the future for generations to come. By including the American Cancer Society in your will, you'll be leaving a loving and lasting impression on life.

You see, cancer is beatable. The survival rate for all cancers is already approaching 50% in the United States.

You'll be giving a gift of life to the future. And giving life is the greatest way of leaving your mark on it.

AMERICAN CANCER SOCIETY®

For more information, call your local ACS Unit or write to the American Cancer Society, 4 West 35th Street, New York, NY 10001.



Health Care At Its Best: Air Force Medicine

Air Force medicine is one of our best benefits, and, with your help, we'll keep it that way. The Air Force needs physicians such as you to become members of our health care team.

Most administrative responsibilities are in the hands of others, giving our physicians the time to give their full attention to the patients' needs. Our hospitals are staffed with dedicated, competent professionals.

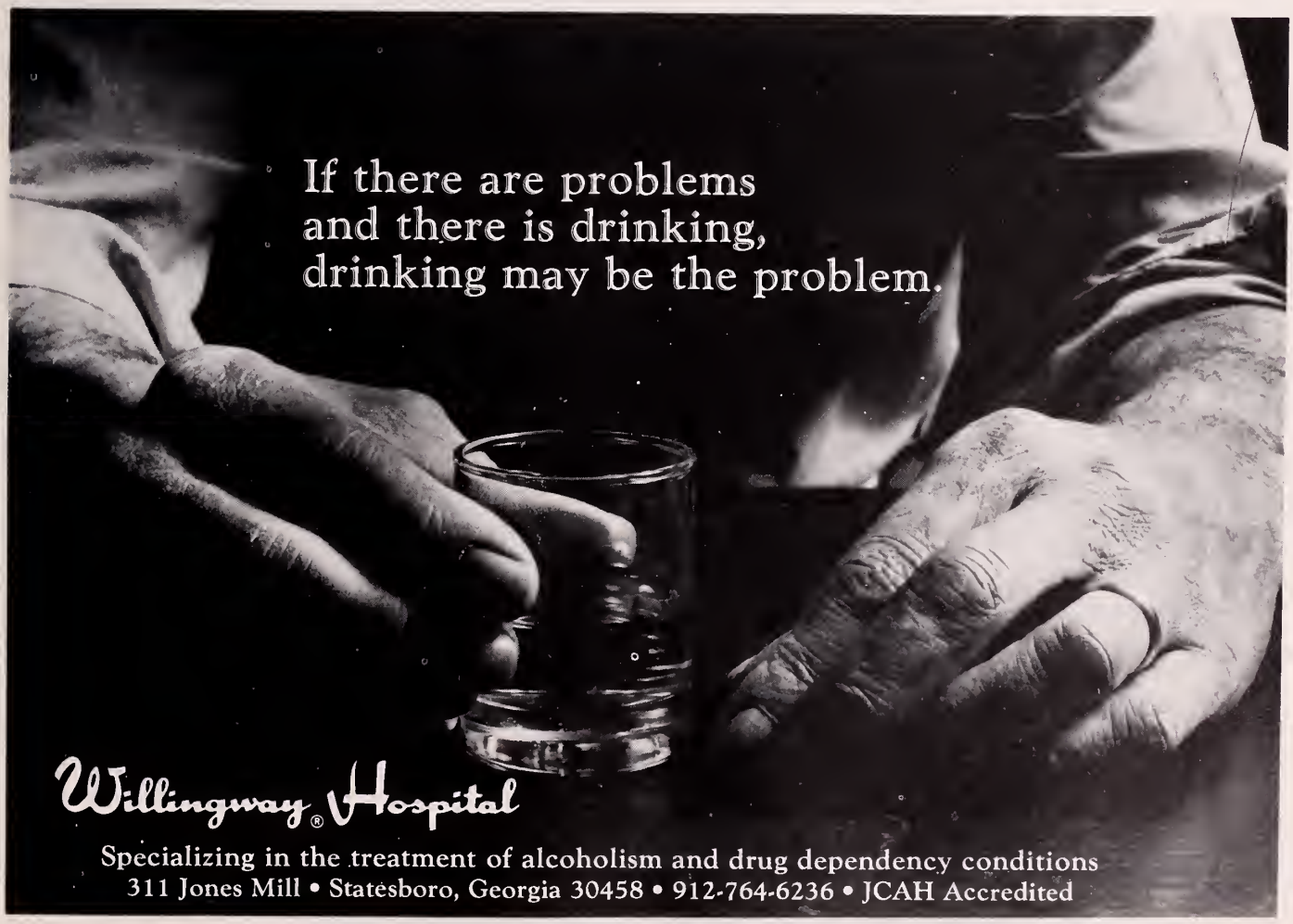
You'll find you will have time for your family, and to keep abreast of the latest methods and technologies that you don't have time for now. We also offer unlimited professional development and financial security.

If you're considering a change, consider Air Force medicine. To find out more about Air Force medicine, contact your nearest Air Force recruiter. Experience health care at its best.

Contact: Medical Recruiter, 305/494-2728 or 305/494-2730. An equal opportunity employer.

AIR FORCE

A great way of life.





KEY LIME PIE

"This tried and true recipe is best with a graham cracker crust. It's easy and can be done ahead!"

4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice, mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used.

Mrs. Michael John Murray (Candy)
Lee County

Rx for fine dining.

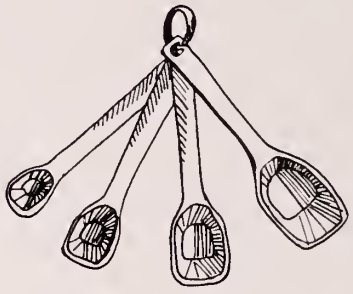
—A collection of over 700 gastronomical delights.

—Eight sections from appetizers to desserts - including many outstanding game, seafood and sauce recipes.

—Full color cover with original pen and ink illustrations dividing the sections.

—Spiral bound and indexed with menus, helpful hints and potpourri.

—Compiled by the Florida Medical Association Auxiliary for the benefit of health related projects.



Rx FOR FINE DINING
P.O. Box 2411
Jacksonville, FL 32203

Please send me _____ copies of Rx For Fine Dining at $10.00 per copy plus $1.30 for postage and handling. Florida residents add $.50 sales tax.

Make checks payable to — COOKBOOK PROJECT, FMA-A
P.O. BOX 2411
JACKSONVILLE, FL 32203

Name _____

Address _____

City, State, Zip _____

COOKBOOKS MAKE GREAT GIFTS!

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

AMA-ERF supports quality medical education and health care

Today's physicians function in a world of acronyms and alphabet soup. One member of this group with which you should be familiar is AMA-ERF — American Medical Association Education and Research Fund. The AMA-ERF Foundation was established to help support quality education in our nation's medical schools.

AMA-ERF is one of the most important committees of the AMA and FMA Auxiliaries. Because AMA-ERF is our only national philanthropic endeavor, it is our committee's job to inspire our members to raise the funds that will help to meet the needs of our nation's medical students and schools.

AMA-ERF contributions are tax deductible and can be designated for three distinct funds: the Medical School Excellence Fund, the Medical Student Assistance Fund, or the Research Fund. In addition to the fund, you may also designate the medical school which is to receive your contribution.

The Medical School Excellence Fund is the oldest of the funds and the largest. It provides grants to medical schools to be used at the discretion of the deans. The Medical Student Assistance Fund provides funds to medical schools to use in direct financial aid to students. Although specific programs vary with the individual medical schools, each school is required to use the funds to help support bona fide educational expenses for medical students recognized as being in need by the school. The Research Fund is used at the discretion of the Foundation to support pilot and experimental health and medical programs.

In 1985, the AMA-ERF Foundation distributed more than $1.6 million in grants to medical schools. Last year, our state contributed $136,059.39 to AMA-ERF. We were second in the nation! Each county's physicians and auxilians played a role in this impressive result.

We hope to increase our state's contributions by a minimum of 10% in order to achieve a monetary goal of $150,000. Auxilians will raise the bulk of this money by selling holiday cards, participating in County Holiday Sharing Cards, and by contributing to state projects such as the Country Craft Store held at our recent Fall Conference.

If you are interested in helping not only the Auxiliary, but also in supporting the medical school from which you graduated, please consider making all or part of your annual alumni donation through AMA-ERF. The medical school will be notified of your donation, and thus, your obligation to the alumni fund of your alma mater is fulfilled. Your contribution will also boost both Florida's and your county Auxiliary's AMA-ERF totals. It is as simple as writing one check to benefit AMA-ERF!

According to the 1985-86 AMA-ERF Workbook, "The consistent generosity of the medical family for medical education is tangible proof of the dedication of the practicing profession to continuing excellence in medical education and to improving health care for the future." Florida physicians and auxilians have participated in AMA-ERF fund raising projects in order to insure today's medical students of quality educational programs and to help provide the best health care possible for our state's citizens. Your generosity has contributed to AMA-ERF's past effectiveness and will help to assure its future success.

Thank you for your continued support of AMA-ERF. Would it not be wonderful to have Florida be number one in the nation in AMA-ERF contributions?

Mrs. Randall deB. (Sue) Bertolette
State AMA-ERF Chairman
Vero Beach

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

THE WORLD BOOK ENCYCLOPEDIA is now available through the FMA Magazine Program. Write or call for complete details of any current promotional offer.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

29 Glen Cove Ave., Glen Cove, N.Y. 11542 516-676-4300

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

WE ARE REPRESENTATIVES FOR WORLD BOOK ENCYCLOPEDIA! Special: $100 off for educators until 12/3/85

Our members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION (No. of iss. per year)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR (No EDUC. of PRICE iss)
American Artist(12)	19.00	19.00	10.97(9)
American Cage-Bird(12)	15.00	12.00	12.00
American Health(10)	14.95	12.95	11.95
American Heritage(6)	24.00	18.00	18.00
Amer.Photographer(12)	19.90	9.95	6.65(8)
2 yrs(24)		19.90	
Americana(6)	11.95	11.95	9.95
Analog:Sci-Fi(13)	19.50	19.50	9.97(10)
Antique Monthly(18)	18.00	18.00	13.00(12)
ArtNews(12)	29.95	25.95	25.95
Artist's Mag(12)	21.00	21.00	9.97(9)
Arts & Antiques(10)	36.00	29.95	29.95
Asimov Sci-Fi(13)	19.50	19.50	9.97(12)
Astronomy(12)	21.00	21.00	15.75(9)
Atlantic Monthly(12)	9.95	9.95	9.95
Attenzione(11)	21.00	21.00	7.97(8)
Audio(12)	17.94	17.94	8.97
Audubon Magazine(6)	16.00	16.00	15.00
Auto Racing Digest(6)	7.95	7.95	5.97
Backpacker(6)	18.00	14.97	14.97
Baseball Digest(12)	14.95	14.95	7.97(10)
Basketball Digest(8)	9.95	9.95	7.97
Beauty Digest(12)	15.00	15.00	15.00
Better Health/Liv.(6)	15.00	15.00	11.97
#Better Hms-Gdns(12)	12.97	6.49	
#Bicycling(10)	15.97	8.00	11.97
Bird Watchers Dig(6)	11.00	11.00	11.00
Black Enterprise(12)	15.00	9.00	7.50
Boating(12)	20.00	16.97	16.97
Bon Appetit(12)	15.00	15.00	15.00
Bowling Digest(6)	12.00	12.00	9.97
Boys Life(12)	13.20	13.20	11.97
Brides(6)	12.00	9.00	
2 yrs(12)		16.00	
Car & Driver(12)	17.00	11.99	11.99
Car Craft(12)	12.94	12.94	7.97
Cats (12)	17.50	17.50	12.50
Cat Fancy(12)	17.97	17.97	12.97
Changing Times(12)	15.00	9.97	9.97
Child Life:age 6-10(8)	11.95	11.95	9.97
Childrens Dig:7-11(8)	11.95	11.95	9.97
Childrens Playmate(8)	11.95	11.95	9.97
Circle Track(12)	19.95	11.95	11.95
Coinage(12)	14.00	14.00	11.95
Collectors Mart(6)	18.00	18.00	15.96
Columbia Journ.Rev(6)	16.00	16.00	9.95
Commentary(12)	33.00	33.00	33.00
#Connoisseur(12)	19.95	10.00	19.95
Consumers Reports(12)	16.00	16.00	16.00
Cons.Rep.Travel Letter(12)		37.00	37.00
Crafts Magazine(12)	15.00	15.00	15.00
Cross Country Ski.(5)	11.97	9.97	8.97
Cruise Travel(6)	12.00	7.97	12.00
Cruising World(12)	18.00	18.00	14.00
Cycle(12)	14.00	14.00	6.99
Cycle World(12)	13.94	13.94	6.97
Daytime TV(12)	19.00	19.00	12.95
Digital Audio(12)	19.97	19.97	16.97
#Discover(12)	24.00	13.00	14.95
2 yrs(24)		26.00	
Dog Fancy(12)	17.97	17.97	12.97
Dog World(12)	20.00	20.00	14.97
Downbeat(12)	15.75	15.75	7.95
Ebony(12)	16.00	14.00	9.97
The Economist(52)	85.00	51.00	51.00
Ellery Queen Myst(13)	22.75	19.50	9.97(10)
Esquire(12)	17.94	9.95	9.95
Essence(12)	12.00	12.00	9.00
Fact(12)	22.00	22.00	18.00
Family Circle(17)	14.97	14.97	
Family Computing(12)	19.97	11.97	11.97
Family Handyman(10)	9.95	9.95	5.95
Field & Stream(12)	13.94	7.94	7.94
2 yrs(24)		15.88	
Fifty Plus(12)	15.00	11.97	
2 yrs(24)		23.94	
Financial World(26)	41.95	24.94	18.95(18)
Fishing/Hunt.News(52)	29.95	29.95	21.95
Flying(2)	19.00	15.97	15.97
Food and Wine(12)	18.00	9.00	15.00
2 yrs(24)		18.00	
Football Digest(12)	12.95	12.95	7.97(10)
Forbes(28)	42.00	42.00	28.00
Fortune(26)	42.00	21.00	21.00
Forum(12)	18.00	18.00	15.00
Games Magazine(12)	15.97	15.97	15.97
2 yrs(24)		24.97	
Gentlemens Quart.(12)	18.00	13.50	
2 yrs(24)		27.00	
Glamour(12)	15.00	12.00	
2 yrs(24)		22.00	
Golf Digest(12)	19.94	9.97	9.97
Golf Illustrated(12)	12.00	12.00	6.00
Golf Magazine(12)	15.94	8.97	7.97
Good Housekeeping(12)	14.97	14.97	14.97
Gourmet(12)	18.00	13.50	15.00
2 yrs(24)		25.00	
Great Foods Mag.(6)	9.95	9.95	7.95
#Harpers Bazaar(12)	16.97	8.97	16.97
Harpers Magazine(12)	18.00	11.97	11.97
Health(12)	22.00	15.97	11.00
High Fidelity(12)	13.95	6.98	6.98
High Technology(12)	21.00	21.00	15.00
Hitchcock Mystery(13)	19.50	19.50	9.97(10)
Hockey Digest(8)	9.95	9.95	7.97
Home(12)	15.00	15.00	11.97
Home Mechanics (12)	11.94	6.94	6.94
2 yrs(24)		13.88	
The Homeowner(10)	18.00	13.97	7.50
Horizon(12)	21.00	21.00	16.00(10)
Horseman(12)	11.95	11.95	7.95
Hot Rod(12)	13.94	13.94	8.97
House and Garden(12)	24.00	18.00	
2 yrs(24)		36.00	
#House Beautiful(12)	15.97	7.99	15.97
Humpty Dumpty:4-7(8)	11.95	9.97	9.97
Hunting(12)	13.94	13.94	9.97
Inc(12)	24.00	12.00	12.00
Income Opportun.(12)	7.95	7.95	3.98(10)
Infoworld(51)	31.00	29.58	29.58
Inside Sports(12)	18.00	11.97	9.97
2 yrs(24)		23.94	
Instructor(9)	20.00	20.00	12.97
Jack & Jill:age 6-8(8)	11.95	9.97	9.97
Jerusalem Post(24)	18.46	18.46	15.97
Jet(52)	36.00	30.00	26.00
Jr. MD: age 9-13(4)	11.95	11.95	8.95
Ladies Home Jrnl(12)	20.00	17.97	10.00
Learning(9)	18.00	18.00	9.90
#Life(12)	27.00	13.50	22.50(10)
M:Civilized Man(12)	24.00	24.00	24.00
2 yrs(24)		42.00	
Mademoiselle(12)	15.00	12.00	
2 yrs(24)		22.00	
Medical Update(9)	12.00	12.00	9.95
Metropolitan Home(12)	15.00	7.50	7.50
Modern Photography(12)	13.98	7.98	6.99
Modern Screen(6)	14.70	14.70	11.70
#Money(12)	29.95	15.00	19.95
Mother Earth News(6)	18.00	18.00	14.97
Mother Jones(12)	18.00	12.00	12.00
Motor Trend(12)	13.94	7.97	7.97
#Motorboat.& Sail(12)	15.97	7.97	15.97
Motorcyclist(12)	11.94	6.97	6.97
MS Magazine(12)	16.00	10.97	10.97
2 yrs(24)		21.94	
Musician(12)	18.00	18.00	10.97
National Geograph(12)	16.50	16.50	16.50
Nat'l Geogr.World(12)	9.95	9.95	9.95
National Lampoon(12)	9.95	9.95	9.95
National Law Jnl.(52)	55.00	55.00	27.50
The Nation (52)	28.00	28.00	9.95(24)
Natural History(12)	20.00	15.95	15.95
Needle and Thread(6)	14.00	14.00	10.50
Needlcrft.for Today(6)	14.00	14.00	10.50
New England Journal of Medicine(52)			
Physicians:		55.00	
Residents and Interns:		35.00	
Students:		30.00	
New Age Journal(12)	18.00	18.00	15.00
New Republic (52)	48.00	48.00	28.00
#New Shelter(9)	10.97	5.50	9.97
2 yrs(10)		10.97	
N.Y. Rev.of Books(17)	28.00	28.00	25.95
New Yorker(52)	32.00	32.00	20.00
2 yrs(104)		52.00	40.00
Newsweek(52)	41.00	20.80	20.80
2 yrs(104)		41.60	
Nursing Life(6)	12.95	12.95	12.95
Old House Journal(12)	16.00	13.95	13.95
Omni(12)	24.00	15.96	15.96
1001 Home Ideas(12)	22.00	15.97	11.00
Opera News(17)	30.00	30.00	24.95
Organic Gardening(12)	12.97	9.97	9.97
Outdoor Life(12)	13.94	6.97	7.97
2 yrs(24)		13.94	
Outside(10)	16.00	12.00	8.97
Ovation(12)	16.00	8.00	8.00
PARENTS(12)	18.00	9.00	11.95
2 yrs(24)		18.00	
Penny Power:Age 9 up(6)		11.95	11.95
Penthouse(12)	36.00	30.00	30.00
People(52)	51.50	51.50	25.75
Personal Computing(12)	18.00	18.00	8.97(9)
Petersens Photog(12)	13.94	6.97	6.97
Playbill(12)	15.00	15.00	15.00
Playboy(12)	22.00	19.00	19.00
Playgirl(12)	20.00	20.00	17.50
Popular Bridge(6)	9.95	9.95	7.95
#Popular Mechanics(12)	13.97	7.00	13.97
Popular Photogr.(12)	11.97	5.99	5.99
Popular Science(12)	13.94	7.97	7.97
2 yrs(24)		15.94	
Present Tense(4)	14.00	8.77	8.77
#Prevention(12)	13.97	7.00	13.97
2 yrs(24)		13.97	
Pro Football Wkly(33)	39.00	39.00	17.00(15)
Psychology Today(12)	15.99	12.97	12.97
2 yrs(24)		25.94	
Radio Electronics(12)	15.97	11.97	11.97
Reader's Digest(12)	15.41	15.41	15.41
#Redbook(12)	11.97	6.97	11.97
Road and Track(12)	17.94	10.99	10.99
Rolling Stone(26)	19.95	19.95	17.95
The Runner(12)	16.97	12.97	8.65(8)
#Runner's World(12)	19.95	10.00	12.97
2 yrs(24)		19.95	
Sail(12)	21.75	21.75	21.75
2 yrs(24)		38.00	
Salt Water Sptsmn(12)	18.00	18.00	18.00
Saturday Eve.Post(9)	12.97	12.97	12.97
Saturday Review(6)	16.00	16.00	12.00
Savvy(12)	12.00	12.00	6.00
Science '85(11)	18.00	18.00	13.95
#Science Digest(12)	13.97	6.99	13.97
The Sciences(12)	12.00	12.00	12.00
Scientific Amer.(12)	24.00	24.00	24.00
Sea Magazine(12)	15.94	8.97	8.97
Self(12)	15.00	12.00	N.A.
Seventeen(12)	13.95	13.95	13.95
Shape(12)	20.00	20.00	8.97(6)
2 yrs(24)		35.00	
Ski(8)	11.94	6.97	6.97
Skiing(7)	9.98	4.99	4.99(7)
Skin Diver(12)	13.94	6.97	6.97
Soap Opera Digest(26)	39.00	39.00	29.75
Soccer Digest(6)	7.95	7.95	5.97
Sport(12)	17.50	9.97	7.97
Sporting News(26:6 mo)	22.50	12.88	12.88
#Sports Afield(12)	13.97	6.99	13.97
Sports Fitness(12)	26.50	26.50	26.50
#Sports Illustr.(52)	53.50	32.00	26.75(54)
The Star(52)	32.00	19.98	19.98
Stereo Review(12)	9.97	4.99	4.99
Stereophile(12)	20.00	14.97	14.97
Success Magazine(12)	17.94	17.94	8.97
Superfit(6)	14.97	11.97	9.97
Teen(12)	12.95	7.95	6.95
Teen Beat(12)	11.95	11.95	10.95
Tennis(12)	17.94	8.97	8.97
Theatre Crafts(10)	24.00	14.95	14.95
#Time(52)	58.25	29.25	28.00(50)
#Town & Country(12)	24.00	12.00	24.00
Tours & Resorts(6)	12.00	9.97	9.97
Travel & Leisure(12)	25.00	12.50	25.00
True Story(12)	14.95	8.97	8.97
Turtle: pre-school(8)	11.95	11.95	9.97
TV Guide(52)	31.20	31.20	26.00
Twilight Zone(6)	15.00	11.97	11.97
USA Today(260)	92.00	92.00	78.00
#U.S.News/Wrld.Rep(52)	41.00	20.50	20.50
2 yrs(104)		41.00	
U.S.News Washington Letter		39.00	39.00
Us Magazine(26)	23.95	17.95	14.95
Vanity Fair(12)	12.00	9.00	
Vegetarian Times(12)	19.95	14.95	14.95
Venture(12)	18.00	18.00	9.00(15)
Video(13)	15.00	15.00	7.50
Video Review(12)	12.00	6.97	6.97
Village Voice(52)	32.76	32.76	16.50
Vogue(12)	24.00	21.00	
W Magazine(26)	26.00	23.00	17.95
Wash.Post Nat.Wkly(26)	52.00	52.00	52.00
Weight Watchers(12)	13.97	11.97	11.97
W.Coast Rev of Bks(6)	12.00	8.94	8.94
Wind Surf Magazine(12)	19.00	17.95	17.95
Winning[Bicycle](12)	19.95	17.95	17.95
Woman's Day(17)	15.13	15.13	15.13
Women's Sports(12)	12.95	12.95	8.95
Workbasket(6)	6.00	6.00	5.00
Workbench(6)	6.00	6.00	5.00
Working Mother(12)	11.95	9.95	9.95
Working Woman(12)	18.00	12.00	15.00
World Press Review(12)	17.95	17.95	11.98
World Tennis(12)	15.94	15.94	7.97
Writer's Dig.(9 iss)	18.00	9.97	9.97
Yachting(12)	20.00	20.00	16.97
Yankee (Colonial)(12)	15.00	15.00	12.97
YM(12)	14.00	10.95	10.95

#Business Card needed for Office Price

FMA MAGAZINE PROGRAM
29 Glen Cove Ave., Glen Cove, N.Y. 11542

MAIL MAGAZINES TO:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AFFILIATED HOSPITAL/SCHOOL _____
Required for Educator rates

VISA or M/C No. _____ Exp. Date _____

Prices subject to publishers' changes.

PLEASE SEND THE FOLLOWING MAGAZINES:

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

All subscriptions are for one year unless otherwise noted.
Guarantee: Our prices are the lowest, our service the best.
New Orders: Publishers take from 6 to 12 weeks to start your subscription.
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.

Please make checks payable to: FMA Magazine Program

FLMD985

Meetings

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

FEBRUARY

Ultrasound Integrated into Modern Ob-Gyn, Miami Beach. Contact: William A. Little, M.D., P.O. Box 016960, Miami, FL 33101, (305) 549-6944.

Awkward Moments — How to Resolve them In the Psychotherapeutic Process, Feb. 1, Holiday Inn Lido Beach, Sarasota. Contact: Beryl Adams, 1845 Hillview St., Sarasota, FL 33579, (813) 366-2700.

Internal Medicine — Selected Aspects, Feb. 1-8, Telluride, Colorado. Contact: Gloria Allington, P.O. Box 016960, Miami, FL 33101, (305) 547-6716.

Twelfth Annual Bail Conference in Anesthesiology, Vail, Colorado. Contact: Brian Craythorne, M.D., P.O. Box 016960, Miami, FL 33101, (305) 547-6411.

Controversies in Carcinoma of the Breast, Feb. 1-8, Snowmass, Colorado. Contact: Martin Silbiger, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-2538.

Eighteenth Miami Winter Symposium — Advances in Gene Technology, Feb. 3-7, Hyatt Regency Hotel, Miami. Contact: William J. Whelan, P.O. Box 016960, Miami, FL 33101, (305) 547-6265.

Ninth Annual Advanced Ultrasound Seminar, Feb. 5-8, Palace Hotel, Lake Buena Vista. Contact: Lennard Greenbaum, M.D., Orlando Regional Medical Center, Orlando 32806-2093, (305) 841-5144.

Hair Replacement Surgery for the Beginner, Feb. 5-9, Miami Airport Hilton, Miami. Contact: Sorrel S. Risnik, M.D., 9065 S.W. 87 Ave., Suite 109, Miami, FL 33176, (305) 279-6060.

Twelfth Annual Symposium on Cosmetic Surgery, Feb. 6-8, Hyatt Regency, Miami. Contact: Thelma MacGregor, 1400 N.W. 12th Avenue, Miami 33136.

Twenty-third Annual Neuro-ophthalmology Course, Feb. 6-8, Sonesta Beach Hotel, Key Biscayne. Contact: Hilary Hose, 6125 S.W. 31 Street, Miami, FL 33155, (305) 667-7060.

Disney World Trauma Symposium, Feb. 6-9, Hilton Inn, Lake Buena Vista. Contact: Robert Youngblood, 1704 S. Tarboro St., Wilson, NC 27893, (919) 291-7001.

ECG Workshop, Feb. 7, Hilton Hotel, Jacksonville. Contact: Merrill A. Anderson, M.D., 4057 Carmichael Avenue, Jacksonville 32207, (904) 398-5667.

Flexible Sigmoidoscopy Workshop, Feb. 7, Hilton Hotel, Jacksonville. Contact: Merrill A. Anderson, 4057 Carmichael Avenue, #229, Jacksonville 32207, (904) 398-5667.

Fortieth Regional Family Practice Weekend, Feb. 7-9, Hilton Hotel, Jacksonville. Contact: Merrill A. Anderson, FAFP, 4057 Carmichael Ave., #229, Jacksonville 32207, (904) 398-5667.

1986 OB/GYN Gold Coast Conference, Feb. 10-12, Good Samaritan Hospital, West Palm Beach. Contact: Barbara Brezner, P.O. Box 3166, West Palm Beach 33402.

Urologic and Potential Problems in Pregnancy, Feb. 10-12, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Pulmonary, Allergy and Infectious Diseases, Feb. 10-14, Palace Hotel, Lake Buena Vista. Contact: Udaya Prakash, M.D., 200 1st Street, S.W., Rochester, MN 55905, (507) 284-2511.

Communicating with Patients, Feb. 13-14, Hyatt Regency, Tampa. Contact David H. Smith, Ph.D., USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 974-3294.

Flexible Fiberoptic Sigmoidoscopy, Feb. 13-16, Orlando Airport Marriott, Orlando. Contact: Edward J. Kowalewski, M.D. 132, E. 70th St., New York, NY 10021, (212) 517-7520.

Economics of Diagnostic Imaging, Feb. 13-14, Palace Hotel, Lake Buena Vista. Contact: Lawrence Muroff, (813) 873-2090.

Pediatrics for the Practitioner, Feb. 14, USF College of Medicine, Tampa. Contact: Herbert Pomerance, M.D., 12901 N. 30th Street, Tampa, FL 33612, (813) 974-4214.

Third Annual Lykes Cancer Center Symposium, Holiday Inn Surfside, Clearwater Beach. Contact: Roger Lapp, Clearwater Seminars, (813) 443-1081.

Seventh Annual International Gastroenterology Conference, Feb. 16-20, Hilton Hotel, Lake Buena Vista. Contact: Sidhi Tewari, M.D., (305) 841-5144.

Strategies in Oncology/ Hematology for the Family Practitioner, Feb. 17-22, Saddlebrook Resort, Tampa. For more information: Marge Adey, 42nd Dewey Avenue, Omaha, Neb. 68105, (402) 559-4152.

Conference on the Beach, Feb. 17-22, Daytona Hilton, Daytona Beach. Contact: Tariq Siddiqui, M.D., P.O. Box 1990, Daytona Beach, FL 32015, (904) 254-4051.

Strategies in Oncology, Feb. 18-22, Saddlebrook Resort, Tampa.

International Symposium on the Biomedical Sciences, Feb. 19-21, Holiday Inn Surfside, Clearwater. Contact: Andor Szentivany, M.D., Univ. of S. Fla., (813) 974-2196.

Sarasota Vitreoretinal Update Course, Feb. 20-22, Colony Beach and Tennis Resort, Longboat Key. Contact: James Kingham, M.D., (813) 921-5335.

Practical Aspects of Newer Cardiovascular and Renal Drugs, Feb. 20-23, Orlando. Contact: University of Miami, Division of CME D23-3, P.O. Box 016960, Miami, 33101, (305) 547-6716.

Pediatric Dermatology Seminar, Feb. 20-23, Eden Roc Hotel, Miami Beach. Contact: Guenter Kahn, 16800 N.W. 2nd Ave. #401, N. Miami Beach, FL 33169.

Thirteenth Annual Symposium in Pediatric Nephrology, Feb. 23-27, Miami. Contact: Univ. of Miami;, P.O. Box 016960, Miami, FL 33101, (305) 549-6726.

Update on Surgery and Management of Colorectal Diseases, Feb. 24-26, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach, FL 33402, (305) 650-6236.

Neurology Update, Feb. 25-March 2, Sheraton Bal Harbor, Bal Harbour. Contact: Division of CME, D23-3, P.O. Box 016960, Miami, FL 33101, (305) 547-6716.

Office Skills Workshop for Primary Care Physician, Feb. 26-28, Florida Hospital, Orlando. Contact: Ted Hamilton, M.D., 2501 N. Orange Ave., Orlando, FL 32804, 897-1514.

Eleventh Annual Midwinter Seminar in OB/GYN, Feb. 26-March 1, St. Petersburg Beach. Contact: J.M. Ungram, M.D., 12901 N. 30th St., Tampa, FL 33617, (813) 974-2088.

Eighteenth Teaching Conference in Clinical Cardiology, Feb. 26-March 1, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., D-41, P.O. Box 016960, Miami, FL 33101, (305) 547-6491.

Cancer Conference, Feb. 27-March 1, Halifax Hospital, Daytona Beach. Contact: Halifax Hospital, Medical Center Education Services, P.O. Box 1990, Daytona Beach, FL 32015, (904) 254-4053.

Health Care of the Elderly, Feb. 27-March 1, USF College of Medicine, Tampa. Contact: Eric Pfeiffer, M.D., 12901 N. 30th St., Tampa, FL 33612, (813) 974-4355.

Current Concepts in Surgery of the Gastrointestinal Tract, Feb. 27-March 1, Diplomat Hotel, Hollywood. Contact: University of Rochester, 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Surgical Anatomy of the Eyelids, Orbit and Lacrimal Apparatus, Feb. 27-March 1, Lincoln Hotel and USF College of Medicine, Tampa. For more info: Jay J. Older, M.D., 12901 N. 30th Street, Tampa 33612, (813) 974-3170.

Cancer Conference, Feb. 28-March 1, Hilton Hotel, Daytona Beach. Contact: Herman Smith, M.D., 570 Memorial Circle, Ormond Beach, FL 32074, (904) 672-1852.

MARCH

Difficult Questions for Pulmonary Medicine, March 1, The Rusty Pelican, Tampa. Contact: David A. Solomon, M.D., 13000 N. 30th Street (111C), Tampa 33612, (813) 972-2000.

Farrior Ear Surgery Course, March 1-6, USF College of Medicine, Tampa. Contact: J.B. Farrior, M.D., (813) 253-0916.

Internal Medicine 1986, March 2-7, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bodes, M.D., P.O. Box 016760, Miami 33101, (305) 547-6063.

Internal Medicine Update, March 2-8, Palace Hotel, Lake Buena Vista. Contact: Barry Sieger, M.D., (305) 841-5144.

Epidemiology and Prevention of Cardiovascular Disease, March 3-5, Good Samaritan Hospital, West Palm Beach. For more info: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Neuroradiology: New Horizons and Current Concepts, March 3-6, Sheraton Bal Harbour, Bal Harbour. Contact: Robert M. Quercer, M.D., P.O. Box 016960, Miami 33101, (305) 547-6716.

Annual Medical Update, March 3-7, Holy Cross Hospital, Ft. Lauderdale. Contact: Jon Fichtelman, M.D., 4725 N. Federal Hwy., Ft. Lauderdale, FL 33308, (305) 492-5728.

Neuroradiology: New Horizons and Current Concepts of Classic Issues, March 3-7, Sheraton Bal Harbour, Miami. Contact: Joyce E. Freeman, P.O. Box 016960, Miami, FL 33101 (305) 549-6894.

Florida Society of Ophthalmology Annual Meeting, March 6-8, Palace Hotel, Lake Buena Vista. For more info: Florida Society of Ophthalmology, 1133 W. Morse Boulevard, #201, Winter Park 32789, (305) 647-8839.

Ophthalmology Talks, March 7-8, Palace Hotel, Lake Buena Vista. Contact: Avery Weiss, M.D., (813) 974-3170.

Professional Liability in the 80's, March 7-9, Saddlebrook Resort, Wesley Chapel, Jeanette Stone, 35 Lakeshore Drive, Birmingham, AL 35219-0088.

Twenty-First Annual Meeting of the American Society of Contemporary Medicine and Surgery, March 9-13, Diplomat Hotel, Hollywood. Contact: John G. Bellows, M.D., 211 E. Chicago Ave., Suite 1044, Chicago, IL 60611, (312) 787-3335.

Ninth Annual Problems in Rheumatology, March 12-15, Don CeSar Beach Resort Hotel, St. Petersburg Beach. Contact: Bernard Germain, M.D., USF College of Medicine, Box 19, Tampa 33612.

Breast Disease Update III, March 12-16, Hilton Hotel, Lake Buena Vista. Contact: Noel Zusmer, M.D., 4300 Alton Road, Miami Beach, FL 33140, (305) 674-2418.

Clinical Management of the Elderly Patient, March 13-15, Palace Hotel, Lake Buena Vista. Contact: The Health and Education Council, 7201 Rossville Blvd., Baltimore, Md., 21237, (301) 686-3610.

Pediatric Urology; for the Urologist, March 14-16, Doral Beach Hotel, Miami Beach. For more info: American Medical International, 6614 Miami Lakes Dr. East, Miami Lakes 33014, (305) 687-1367.

Pediatric Intensive Care, March 17-19, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Winter Symposium, March 17-20, Hyatt Regency Grand Cypress, Orlando, Contact: Gerald Whelan, M.D., P.O. Box 619911, Dallas, TX 75261-9911, (214) 659-0911.

Eighth Annual Family Practice Review, March 17-21, Adam's Mark Caribbean Gulf Resort, Clearwater Beach. Charles Aucremann, M.D., 701 6th Street South, St. Petersburg, FL 33701, (813) 893-6156.

Infectious Disease and Antibiotic Therapy, March 18-22, Palace Hotel, Lake Buena Vista. Contact: Barry Sieger, M.D., (305) 841-5144.

Contemporary Hepatology, March 20, USF, Tampa. Contact: William Boyd, M.D. (813) 972-2000, ext. 425.

Seventeenth Annual Topics in Internal Medicine, March 20-22, Gainesville Hotel, Gainesville. Contact: A. Jay Block, M.D., JHMHC 19-233, Gainesville, FL 32610 (904) 392-3143.

Issues in Perinatal Care — 1986, March 21-22, Halifax Hospital, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Blvd., Daytona Beach, FL (904) 252-4701.

Vascular and Pulmonary Diseases: Diagnosis and Management, March 21-23, Bahia Mar Hotel, Ft. Lauderdale. Contact: Stephen E. Mattingly, (303) 798-9682.

Advances in Diagnostic Imaging, March 22-30, Switzerland, St. Moritz. Contact: Lawrence Miroff, M.D., (813) 974-7267.

Spring 1986 Family Practice Review, March 24-28, Sheraton World, Orlando. Contact: William Stewart, M.D., JHMHC J-233, Gainesville, FL 32610, (904) 392-4321.

1986 Update on Diseases and Imaging, March 31-April 2, Walt Disney World Village Hotel, Lake Buena Vista. Contact: Charleen Krissman, 12901 N. 3oth Street, Tampa, FL 33612, (813) 974-2538.

APRIL

Critical Care Medicine, April 1-5, Hotel Royal Plaza, Lake Buena Vista. Call: Alan Varraux, (305) 841-5144.

Radiology of Hepatobiliary and Pancreatic Disease: Imaging and Intervention, April 1-5, Miami Hyatt Regency, Miami. Contact: Jill Nolden, Division of Diagnostic Radiology, P.O. Box 016960, Miami, 33101, (305) 549-6894.

Issues and Advances in Pediatrics, April 2-4, Sheraton Sand Key Resort, Clearwater Beach. Contact: Lewis A. Barness, M.D., 12901 N. 30th Street, Box 15C2, Tampa, FL 33612-4799.

Fourth Annual Interventional Radiology Seminar, April 2-5, Palace Hotel, Lake Buena Vista. Contact: Martin Selbiger, M.D., (813) 974-2538.

New Approaches to Common Disorders, April 3-5, Adams Mark Resort, Clearwater. Contact: Joel Gleason, M.D., USF College of Medicine, (813) 397-5511.

Regional Cancer Conference, April 8-11, Lake Buena Vista, Lake Buena Vista. Call: Clarence Brown, M.D., (305) 841-5144.

Forty-First Regional Family Practice Weekend, April 11-13, Lincoln Hotel, Tampa. Contact: Robert L. Dawson, M.D., 4057 Carmichael Ave., #229, Jacksonville 32207, (904) 398-5667.

1986 Radiation Therapy Seminar, April 17-19, University Centre Hotel, Gainesville. Contact: Division of Radiation Therapy, JHMHC J-385, Gainesville, 32610.

Clinical Virology Seminars, April 21-23, Holiday Inn Surfside, Clearwater. Contact: Steven Specter, Ph.D., USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 974-2178.

Physiology of Fitness, April 22-26, Sonesta Village Hotel, Orlando. For more info: Alan Varraux, M.D., (305) 841-5144.

MAY

Five-Day Diabetes Management Course, May 12-16, USF College of Medicine, Tampa. Call: Anthony Morrison, (813) 974-4360.

Master Approach to Cardiovascular Problems, May 24-26, Contemporary Hotel, Lake Buena Vista. Contact: Augustin Castellanos, M.D., P.O. Box 016960 (D-39), Miami, FL 33101, (305) 549-7124.

JUNE

Seventh Annual Child Neurology Postgraduate Course, June 9-12, Sonesta Beach Hotel, Key Biscayne. Contact: Oscar Papazian, M.D., 6125, S.W. 31st Street, Miami, FL 33155.

ONGOING

Seminars — Most major ski areas, Club Med, Disney World and other resorts. Topic: Medical/Legal and Financial Management. Accredited. Current Concept Seminars, Inc. (since 1980) 3301 Johnson St., Hollywood, FL 33021 (800) 428-6069. Fee $175.

Physicians' Confidential Assistance

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874 — M D

THE FLORIDA MEDICAL FOUNDATION 1956

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

LAKE BUTLER HOSPITAL HAND SURGERY CENTER

HELPING HANDS ™ HELPING LIVES

The Southeast's Specialized Surgery Center For:

- Injuries and Deformities of Hands and Feet
- Plastic and Cosmetic Surgery
- Reconstructive Microsurgery
- Comprehensive Hand Therapy

(904) 496-2323

24-HOUR EMERGENCY

850 E. Main Street • Lake Butler, Florida

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name:_____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Fern Blum, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

SOUTH FLORIDA FAMILY PRACTICE — Very busy two-man practice, fully-equipped, new ambulatory center, rapidly expanding. Need young, bright, energetic and empathetic physician with view to full partnership. Excellent salary, benefits, insurance, etc. Florida license required. Send curriculum vitae to: Sunshine Medical Center, 6341 Sunset Drive, South Miami, Florida 33143. All inquiries strictly confidential.

FAMILY PRACTICE opportunity: South Miami area. Board eligible or certified preferred. Excellent pay and working conditions. Affiliated with major medical center. Full or part-time. Respond with C.V. to Box C-1306, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE: Physician needed in expanding 153 bed hospital to manage ICU, surgical and diverse medical patients in correctional setting. Well equipped facility near Gainesville and UF with competitive salary and good benefits. No O.B. or evening/weekend call. Please call John E. Metheny, M.D., at (904) 496-2222, Ext. 121 or send CV to Medical Director, Reception and Medical Center, P.O. Box 628, Lake Butler, Florida 32054.

PEDIATRICIAN: 32 physician, multi-specialty group practice accepting applications for a full time, energetic pediatrician. Send CV to: Administrator, Suncoast Medical Clinic, 700 Sixth Street South, St. Petersburg, FL 33701.

FLORIDA MEDICAL DIRECTOR: Full-time salaried position directing a staff consisting of thirty-one (31) full-time physician employees. 180 bed acute care facility, not for profit, located in Bartow, Florida, approximately equal distance from Tampa and Orlando, near Winter Haven and Lakeland. Must be licensed in Florida with a minimum of five (5) years leadership/management experience. Board certified in at least one specialty. Position reports to the Board of Trustees through the Hospital Administrator. Interested parties should send CV to: Hospital Administrator, Polk General Hospital, P.O. Box 816, Bartow, FL 33830.

PRIMARY CARE CENTERS IN FLORIDA, NEW YORK, NEW JERSEY: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full time basis. Positions available in Central and South Florida coastal communities, central and northern New Jersey, and Long Island, New York area. Guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 930 South Harbor City Blvd., Suite 307, Melbourne, FL 32901.

ESTABLISHED, BOARD CERTIFIED, F.A.C.O.G. seeks female or male board certified/board eligible to join in practice locating in central Florida. Attractive first year salary, leading to full partnership, fringe benefits. Send curriculum vitae to: Post Office Box 392, Lakeland, Fl. 33802.

THORACIC AND GENERAL SURGERY, DERMATOLOGY, FAMILY PRACTICE, and RADIOLOGY: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

PRIMARY CARE FACILITY in West Palm Beach seeking P/T physicians for hourly work and full time physicians for future facilities. Send CV to P.O. Box 16474, West Palm Beach, FL 33416.

ORLANDO — Family practice BE/BC career opportunity high quality, unique concept for FP's to meet challenge of medicine's change. Compensation guarantee, incentive with option to buy in. Must be ambitious, intense, and have impeccable credentials, Fla. license. Troy Overstreet, 120 Sunnytown Road, Casselberry, FL 32707, (305) 339-7171.

RADIOLOGIST for private outpatient clinic, Coastal Florida City. Approximately 15-20 hours per week. No weekends or nights. Ideal for retiring physician. Send reply to C-1308, Box 2411, Jacksonville, Fl. 32203.

FAMILY PRACTICE, INTERNAL MEDICINE, EMERGENCY, M.D.'s needed for rapidly expanding network of ambulatory care centers in the Tampa Bay Area of Florida's Gulf Coast. Paid malpractice/competative salary/flexible work schedule/plus generous incentive packages. Please call or respond with CV to: Kendal B. Stiles, M.D., Medical Director, United Gulf Medical Centers, P.O. Box 31272, St. Petersburg, FL 33732. Ph.: (813) 896-2431.

FORT LAUDERDALE, MIAMI, PALM BEACH. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, Florida 33317

EMERGENCY PHYSICIAN, U.S. Residency-trained and Board Certified by A.B.E.M. needed to five-man fee-for-service group in Sarasota. 800 bed full-service hospital. Immediate full status in group. Call S. Newman, M.D. at (813) 923-6317 or send CV to S. Newman, M.D., Memorial Hospital, 1700 S. Tamiami Trail, Sarasota, Florida 33579.

ORTHOPAEDIC SURGEON: Second orthopaedic surgeon to join a twenty-two member multi-specialty clinic. Board certified or board eligible. Guaranteed salary with incentive bonus. Clinic is located in the heart of the Florida citrus industry and lake country. 1½ hours to either coast! Immediate drawing area — 90,000. For additional information, sent CV to C-1318, P.O. Box 2411, Jacksonville, FL 32203.

SPECIALIST IN GYNECOLOGY looking for an OBS/GYN Board certified or Board eligible associate for a long established practice in Palm Beach County, Florida. Please direct all correspondence and inquiries to: Mrs. J. S. Gray, 2217 22nd Lane, Palm Beach Gardens, FL 33410.

FAMILY, GENERAL OR INTERNAL medicine practitioner needed immediately for a well established, successful Family/General Practice in North Central Florida. Office has laboratory, x-ray, EKG facilities. Board Certified or eligible preferred but not necessary. Send CV to C-1307, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PHYSICIAN to join expanding family practice in Jacksonville. Excellent benefits and growth potential. Board certified or eligible preferred. Send CV to Stephen Clark, M.D., 4131 University Blvd. S., Jacksonville, FL 32216.

INTERNIST — Very busy solo general internist on the east coast of Florida looking for an associate. Great opportunity to step into a thriving practice. Call (904) 428-3241 or (904) 427-1301.

UROLOGIST — Central Florida — established BC urologist in solo practice near Orlando needs BC/BE urologist associate. First year salary and productivity bonus leading to early partnership. Send CV and resume of medical/urological experience to: Joe Stansell and Associates, P.O. Drawer W, Sanford, FL 32772.

TAMPA — Excellent opportunity to become the primary physician of a well established growth oriented Family Practice in the fastest growing city in the South. Practice benefits include association with a specialty group, computerized management system, X-ray, laboratory, spriometry, modern offices in pleasant surroundings. We are seeking a Board Certified or Board Eligible family practitioner, highly motivated and dedicated to delivery of quality health care. Excellent base salary plus strong incentives based on revenues. We will provide assistance with interview and relocation expense. If you would like to be an important part of our growing team, send your CV to C-1314, P.O. Box 2411, Jacksonville, FL 32203.

ENDROCRINOLOGIST — SE Florida coast, 15 MD internist and med subspecialty group, rapid practice growth, guarantee annual income first 2 yrs with excellent additional income prospects, HMO/PPO participation optional, BC preferred, enjoy year round outdoor recreation, beautiful living area, unique cultural opportunities, reply to C-1312.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4204.

GROUP OPENING for residency — trained F.P. to join growing group of young boarded, residency-trained F.P.s. Contact: Roman M. Hendrickson, M.D., P.A., 621 South Nova Road, Ormond Beach, Fl. 32074, (904) 672-5084.

FAMILY PRACTICE/GERIATRICS, active. North Tampa/USF area. Completely equipped office including new X-ray, HME*, Spirometry, and Motorola Cellular portable telephone. Serious inquiries only. C-1289, P.O. Box 2411, Jacksonville, FL 32203

NEUROLOGIST, Board certified or eligible to join a solo practice in a rapidly growing community located in Florida sunbelt. Full EP, EMG, EEG and CT facilities. Plan to expand services. Early full partnership. Reply with CV to Box C-1294, P.O. Box 2411, Jacksonville, FL 32203.

UROLOGIST looking for pleasant associates BC/BE with good patient rapport. Either new to practice or well along in career. Resume and photo. Box 82887, Tampa. 33682-2887.

PEDIATRICIAN — Central Florida — established BC pediatricians in three man practice needs BC/BE pediatrician associate. First year salary and productivity bonus leading to early partnership. Send CV and resume of medical/pediatric experience to: Joe Stansell and Associates, P.O. Drawer W, Sanford, Florida 32772.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T.C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

FLORIDA S.E. COASTAL AREA UNIQUE OPPORTUNITY for someone with Internal Medicine and Emergency Medicine experience. Expanding office based practice-opportunity with equity participation available. Send C.V. in confidence to: SRM & Associates, Inc., 1060 NE 28th Terrace, Pompano Beach, FL 33062.

AN AMERICAN CLINIC abroad seeks two U.S. citizen/permanent resident female BC/BE family physicians with minimum 3 years post residency experience in ob/gyn-pediatrics. Excellent salary and benefits, tax exemption, leaves, insurance and many others. Send resume to I. Modaber, M.D., 525 S. Conway Rd. #12, Orlando, FL 32807.

ESTABLISHED WALK-IN CLINICS — Sarasota Co. Well qualified M.D.'s with primary care background. Excellent working conditions. Pay and incentives according to qualifications. Send CV to T.M. McNaughton, M.D., 540 S. Nokomis Avenue, Venice, FL 33595 or call (813) 484-2167.

TWO POSITIONS AVAILABLE immediately. Excellent opportunity for Family practitioner/Internist. BC/BE in west coast Florida. Immediate appointment with excellent salary, benefits and profit sharing. Reply in confidence to Oneco Medical Center, Attn. B.A. Hooli, P.O. Box 1486, Oneco, FL 34264.

ORLANDO — Physician needed for freestanding ambulatory care center. Competative hourly wage with incentive bonus. Contact Fran Olschner, BVL Family Medical Center, 2531 Boggy Creek Rd., Kissimmee, FL 32743. Phone 305/933-0990 or 305/422-0430.

DUE TO CLINIC EXPANSION, Veterans Administration Outpatient Clinic in West Palm Beach Florida area recruiting for two full-time and one half-time physicians with family practice or internal medicine experience. Boards preferred. Salary commensurate with training and experience. All Federal employment advantages available. VA is an Affirmative Action Employer. Write or call Seymour Chasan, M.D., Chief Medical Officer, VA Outpatient Clinic, 301 Broadway, Riviera Beach, FL, Ph. (305) 845-2800.

VETERANS ADMINISTRATION Outpatient Clinic in West Palm Beach Florida area recruiting for a half-time Urologist. Salary commensurate with training and experience. All Federal employment advantages available. VA is an Affirmative Action Employer. Write or call Seymour Chasan, M.D., Chief Medical Officer, VA Outpatient Clinic, 301 Broadway, Riviera Beach, Florida. Ph. (305) 845-2800.

OB-GYN needed for multi-specialty group; university town in Northwest Tennessee; excellent, fully equipped hospital, JCAH accredited, HCA affiliate. Contact: Joe D. DePew, Administrator, Volunteer General Hospital, P.O. Box 828, Martin, TN, 38237, (901) 587-4261.

WANTED FOR REVIEWING records — Orthopedic Surgeons, Ob-Gyn, Neurosurgeons and plastic surgeons — send your CV to Eve Wadga, Suite 2101, 2 Royal Palm Way, Boca Raton, FL 33432.

Situations Wanted

DIAGNOSTIC RADIOLOGIST: University trained with Fellowship in ultrasound-computed tomography and radiological imaging seeks group practice — hospital or solo. Reply C-1301, P.O. Box 2411, Jacksonville, Fl, 32203.

INTERNIST completing sub-specialty fellowship in pulmonary medicine July 1, 1986 seeking academic and clinical practice group for affiliation. CV, recommendations, etc. on request. Please respond to Warren S. Goff, D.O., 21631 Jacksonville Road, Farmington Hills, Mi. 48027, phone 313-474-4414.

PLASTIC AND RECONSTRUCTIVE SURGEON. Recently completed residency, Board Eligible. Seeking any practice situation; solo, group, partnership, etc. Prefer Florida's Southeast Coast, especially Palm Beach County. Immediately available with Florida license. Reply: Alan A. Yurkiewicz, M.D., 32 Hobart Dr., Apt. C4, Newark, Delaware 19713. Phone (302) 737-7071.

NEURORADIOLOGIST: Board Certified, 2 year University Fellowshop, expertise in pediatric and adult CT, angio, myelo and DSA, also excellent skills in general diagnostic as partner for last 2 years in large multispecialty group. Thirty-five years old, married, one child. President, University of Florida graduating class 1978, who wishes to return home. Lawrence H. Schott, M.D., 1818 Lenard St., Wausau, Wisconsin 54401. (715) 675-9900 evenings.

PHYSICIANS ASSISTANT — Clinic manager. Mature professional BS & MBA skilled in biochem, instrumentation & electro-med fields seeks holistic type S. Fla. association as second career. Two years med-dental study; Ph.D. pending. Expertise includes finance, nutrition, biocomputers, acupuncture, etc. Box 391, Madison, NJ 07940.

PATHOLOGIST, Florida licensed, AP/CP 1985, Fellowship in AP interest in fine needle aspiration. Available November-December 1985. Desire position as a general pathologist anywhere in Florida. Reply: Susanna Kunis, M.D., 521 Howard Ave., Altamonte Springs, FL 32701. Ph. (305) 834-8122 (home) or (305) 841-5219 (work).

THORACIC-VASCULAR GENERAL SURGEON — 62 years young. Excellent health qualifications. Seeks full or parttime position — ER — Assisting — What do you need? Reply C-1317, P.O. Box 2411, Jacksonville, FL 32203.

PHYSICIAN ASSISTANT: Board certified, 36, 7 years experience in family practice and acute care. Personable, enthusiastic, motivated. Practice management skills. Guaranteed to build practice, increase net income. $175K/yr. ave. gross. Reg. salary pkg. with equity sharing. Prefer coastal S.E. U.S., private sector. Robert White, PA-C, 4214 Redwood Ave., Jacksonville, FL 32207, (904) 731-9079.

RADIOLOGIST, Board Certified. Trained and experienced in most modalities. Available for Locum Tenens. Permanent Position considered. C-1309, P.O. Box 2411, Jacksonville, FL 32203.

Practices Available

PEDIATRICS, N.E. COAST. Well established, fully equipped. Excellent community hospital (NICU & Pediatric Ward), charts, office, equipment, good will. Transferable. Easy terms. BE/BC. Contact C-1298, P.O. Box 2411, Jacksonville, FL 32203.

NORTH CENTRAL Florida. University and medical center community. Solo practice. Will phase out if desired. Excellent hospital nearby. C-1305, P.O. Box 2411, Jacksonville, Fl. 32203.

FULLY EQUIPPED MEDICAL CENTER and practice for sale. Southwest Florida tropical island. Phone Sterling International (813) 472-6632 or (813)337-1616. Owner financing available.

FOR SALE — Surgical practice and non-invasive lab. Includes office bldg. Adjacent large hospital. Central Florida. Reply C-1317, P.O. Box 2411, Jacksonville, FL 32203.

RETIREMENT MINDED OB-GYN in north Florida looking for partner in practice grossing 400,000 t. Partnership immediately with transfer of practice in two years. C-1316, P.O. Box 2411, Jacksonville, FL 32203.

RICHARD LEFFERT, DDS, Associate Executive Real Estate, Inc., specializing in Professional Practice Sales & Marketing. 1715 Stickney Point Rd., Suite A, Sarasota, FL 33581, (813) 924-1231 after hours (813) 922-6161.

ESTABLISHED PREVENTIVE MEDICINE and General Practice in Greater Orlando. $29,000 with equipment; willing to introduce to patients and hospital staff; call evenings (305) 886-5361 or write C-1313, P.O. Box 2411, Jacksonville, FL 32203.

FT. LAUDERDALE — C/L PSYCHIATRY: Busy practice, with potential for expansion. Good location, good reputation, good facilities. Associate, then assume. Terms flexible. CV and reply to C-1315, P.O. Box 2411, Jacksonville, FL 32203.

Real Estate

SPRING HILL, FL — 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease — owner will finance. (904) 596-4162 weekdays.

HIGHLAND BEACH, Florida (near Boca Raton). East of Intracoastal. On island, deep canal dock, ocean access, walk to private beach. Low crime community. Four bedrooms/split. Built in 1982. Bette Conlon, (305) 391-9400.

UNIQUE FRANCHISE available to physicians and dentists only. For information call Bob Richardson (305)977-9322.

DOCTOR MUST SELL new luxury prime condo, Park Plaza, 12th Floor. 3 bedroom, 2 bath. Covered parking, pool, magnificent view St. John's River and downtown Jacksonville. Dock available. Below market. Phone (305) 278-1067.

MEDICAL OFFICE FOR RENT OR SALE: Two examination rooms, laboratory. 850 sq. ft. laboratory and office equipment also for sale. Retiring internist. 302 Third Street, Neptune Beach, FL 32233, 246-7485, 246-1175.

THE OPENING OF OUR new Englewood Community Hospital in Englewood, FL (Sarasota County)? provides a unique opportunity for a physician to live in a resort community on the Gulf and grow with an ever busy practice. Contact Dr. E.J. Ryan for a brochure concerning leasing and particulars. Te. (813) 484-4513.

OFFICE SPACE FOR RENT: This beautiful 1,000 sq. ft. of office space is located on the ground floor at two very busy intersections in a Condo area. Broward County. Fantastic exposure. Low rent. Will be available in the Spring of 1986. Scott: 1-800-533-5564, Fl., 685-0750 Dade.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and reconditioned Holter-Stress-Echo-EKG and other medical Electronic Instruments. Contact Ed Bentolila, P.O. Box 8676, Coral Springs, FL f33065, (305) 972-4600.

GREAT SOUTHERN QUAIL hunting at Georgia's fastest-growing quail preserves. Relaxing, enjoyable pastime for busy physicians. Call or write Fred Purvis R.Ph., Mesa Hunt Preserve, Rt. 2 Box 386 A, Adel, Georgia 31620. Tel. (912) 896-2400 or (912) 896-2637 or beeper (912) 333-6001, may leave message.

Equipment

AVAILABLE FOR SALE: Raytheon Model RME-325R X-ray Generator, Raytheon Model TTS 471 Table Tubstand Combination, Machlett DX 42/40 X-ray Tube Unit, Machlett RBL-II Semi Automatic Collimator. Contact John Manry (305) 569-3771 for further information.

APPOINTMENT SCHEDULING SOFTWARE for a small clinic, doctor's or dentist's office with IBM-PC or MS-DOS compatible microcomputer. Very easy to use. Computer background not necessary. Price: $245. Professional Technology Systems, P.O. Box 893, Jensen Beach, FL 33457.

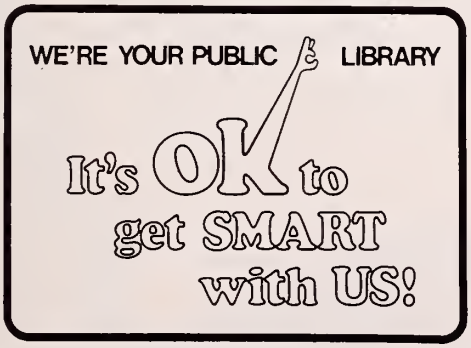
SPECTROSCAN UNIT — complete - $50,000. Raytheon Radiographic room, floating table top, 500 MA generator — $15,000. Both used for less than three months. Will consider offers. C-1309, P.O. Box 2411, Jacksonville, FL 32203.

Meetings

BIOFEEDBACK THERAPIST TRAINING PROGRAM — Six day program (2-3 day weekends) to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. CEU's Available. Jan. 17-19 & Jan. 24-26, or March 1-3 & March 15-17, or May 16-18 & May 30-June 1, or July 11-13 & July 25-27, 1986. For brochure contact: Hartje Stress Clinic, 2429 University Blvd., West., Jacksonville, FL 32217. (904) 737-5821.

FEBRUARY 14-15, 1986. Third Annual Lykes Cancer Center Symposium of Morton Plant Hospital, "The Practical Management of Breast Cancer '86''. Faculty: George Blumenschein, M.D.; James May, M.D.; David Kinne, M.D.; Jay Harris, M.D., Holiday Inn Surfside, Clearwater Beach, FL. Contact: Roger Lapp, R.Ph., Manager, Clearwater Seminars (813) 443-1081, Alan Tralins, M.D., Medical Director, Lykes Cancer Center, (813) 462-7045.

1986 CME CRUISE/CONFERENCES on selected medical topics: Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. Seven-twelve days year-round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) & AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican & Alaskan cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.



THE APPROPRIATE GIFT FOR AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO:

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

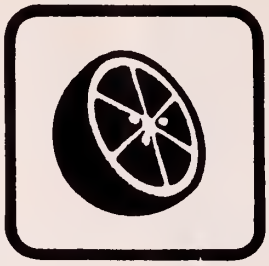
City & State _____

Send the bill for $15.00 (add .75 sales tax if you live in Florida)

Dr. _____

Street _____

City & State _____



Oranges

Eyes, Ears, Noses . . . Temples!

The Fabulous TEMPLE ORANGE — superior quality and taste.

The world's finest eating orange is now available, and only until February 28th can you taste this fabulous fruit.

The TEMPLE is zipper-skinned, with mouth-watering flavor and fragrance . . . what a treat for the entire family.

AND, REMEMBER, January and February are VITAMIN C months. We rarely have a chance to enjoy something so good for us! Good Health never tasted this great.

The demand for TEMPLE ORANGES is great, and the crop and season are short, so ORDER NOW for this FABULOUS ORANGE. Tree ripened and hand-picked at the peak of flavor.

For complete selection, contact your local chairman or president, or contact:
Mrs. Gary Wright
4171 S.E. 38th St.
Ocala, Florida 32671
904-694-2248

ALL BENEFITS GO TO THE FLORIDA MEDICAL FOUNDATION. MAKE CHECKS PAYABLE TO: "FMA-AUXILIARY-FMF"

TEMPLE ORANGES: Pak #2 (½ Bushel) — $22.95
Pak #4 (1 Bushel) — $34.95

Name:_____

Address:_____

Pak No._____ All Temples, All Grapefruit, Or Mix_____

(Please Specify)_____

Gift Card To Read:_____

Price:_____ Arrival Date:_____

Please Send Brochure:_____

He Thought That Drinking Wouldn't Make Any Difference, Even Though He Was on a New Medication. But It Did.



Now he knows that alcohol and some medicines don't mix. In fact, more than half the 100 most prescribed drugs have at least one ingredient that can cause trouble if taken while drinking alcohol. The result of mixing these drugs (alcohol is a drug) may be no more than simple temporary illness, but some combinations can be dangerous, even deadly.

So, don't make a test tube out of your body. Be sure to tell your doctor or druggist about any medications you are taking and be sure to ask about the consequences of mixing a newly prescribed drug with alcohol.

Also, make it a habit to check the label carefully when you get a drug, whether it's a prescription or over-the-counter medication.

And when you get any prescription, be sure you know—

- **The name** of the drug
- **Its purpose**—what conditions does it treat?
- **How and when** to take the drug—and when to stop taking it
- What **food, drinks and other drugs to avoid** while taking it
- What **side effects** may result—are they serious, short-term, long-term, etc.?

If you have any questions about your prescription, *ask your doctor or pharmacist.*

A message from the Food and Drug Administration. For more material about being an informed patient, write to: FDA, HFE-88, Rockville, Md. 20857.

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

THE MEDICAL SYSTEM INCLUDES:

- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

ADVANTAGES

- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

INTERESTED?

For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

The ISI Software Question

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.

ADVERTISERS

Air Force
Recruitment . . . 63

Army Reserves
Recruitment . . . 8

Ayerst Laboratories
Inderide LA . . . 50a

Brown Pharmaceutical
Android . . . 18
Lipo-Nicin . . . 51

Curtis 1000 Information Systems
Computers . . . 22

Eli Lilly & Company
Keflex . . . 2d

Fair Oaks Hospital
Service . . . 23

Florida Physicians' Insurance Reciprocal
Service . . . 2

Future Information Systems
Service . . . 5

GTE Telenet
Service . . . 42

Info Systems
Computers . . . 77

Lake Butler Hospital Hand Surgery Center
Service . . . 70

Medical Education Foundation of Miami
Meeting . . . 18

Parkway Regional Medical Center
Service . . . 40

Roche Products, Inc.
Dalmane . . . 79

University of Alabama
Service . . . 16

University of Miami
Meeting . . . 3, 41, 46

University of South Florida
Seminar . . . 24

Upjohn Company
Motrin . . . 2c

Willingway Hospital
Service . . . 63

Wyeth Laboratories
Ativan . . . 3

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

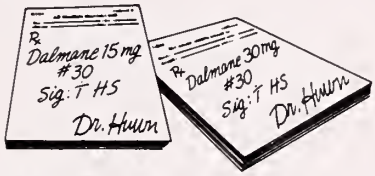
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
flurazepam HCl/Roche Ⓥ
sleep that satisfies

15-mg/30-mg capsules



References: **1.** Koles J, *et al: Clin Phormocol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Phormocol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Phormocol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Phormocol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriotr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behov Med*, pp. 25-31, Oct 1978. **7.** Kales A, Koles JD: *J Clin Psychophormocol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Phormocol Ther 21*:355-361, Mar 1977.



DALMANE®
flurozepam HCl/Rache Ⓥ

Before prescribing, pleose consult complete product informotion, o summory of which follows:

Indicotions: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situotions requiring restful sleep. Objective sleep laboratory dato have shown effectiveness for at least 28 consecutive nights of administratian. Since insomnia is often transient and intermittent, pralanged administratian is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluatian.

Controindicotions: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformatians associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Wornings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precoutions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosoge: Individualize for maximum beneficial effect. *Adults* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitoted potients*, 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Rache Products Inc.
Manati, Puerto Rica 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side

DALMANE®

flurazepam HCl/Roche ⓒ

sleep that satisfies



Copyright © 1985 by Roche Products Inc. All rights reserved.

ROCHE®

STACKS

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. FEBRUARY 1986 Vol. 73, No. 2

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
FEB 25 1986



LEADERSHIP

The majority of seats on the FPIR Board of Directors are held by Florida physicians, many of them elected leaders of the Florida Medical Association. Other seats are held by experienced insurance professionals. Together they provide FPIR with unique leadership for difficult times.



The FPIR is sponsored by the Florida Medical Association and is managed by the Physicians Management Corporation, as subsidiary of the Physicians Insurance Company of Ohio (PICO).

For more information, please contact:

FLORIDA PHYSICIANS
INSURANCE

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

BALANCED CALCIUM CHANNEL BLOCKADE!



CARDIZEM
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

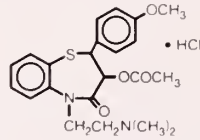
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered.

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

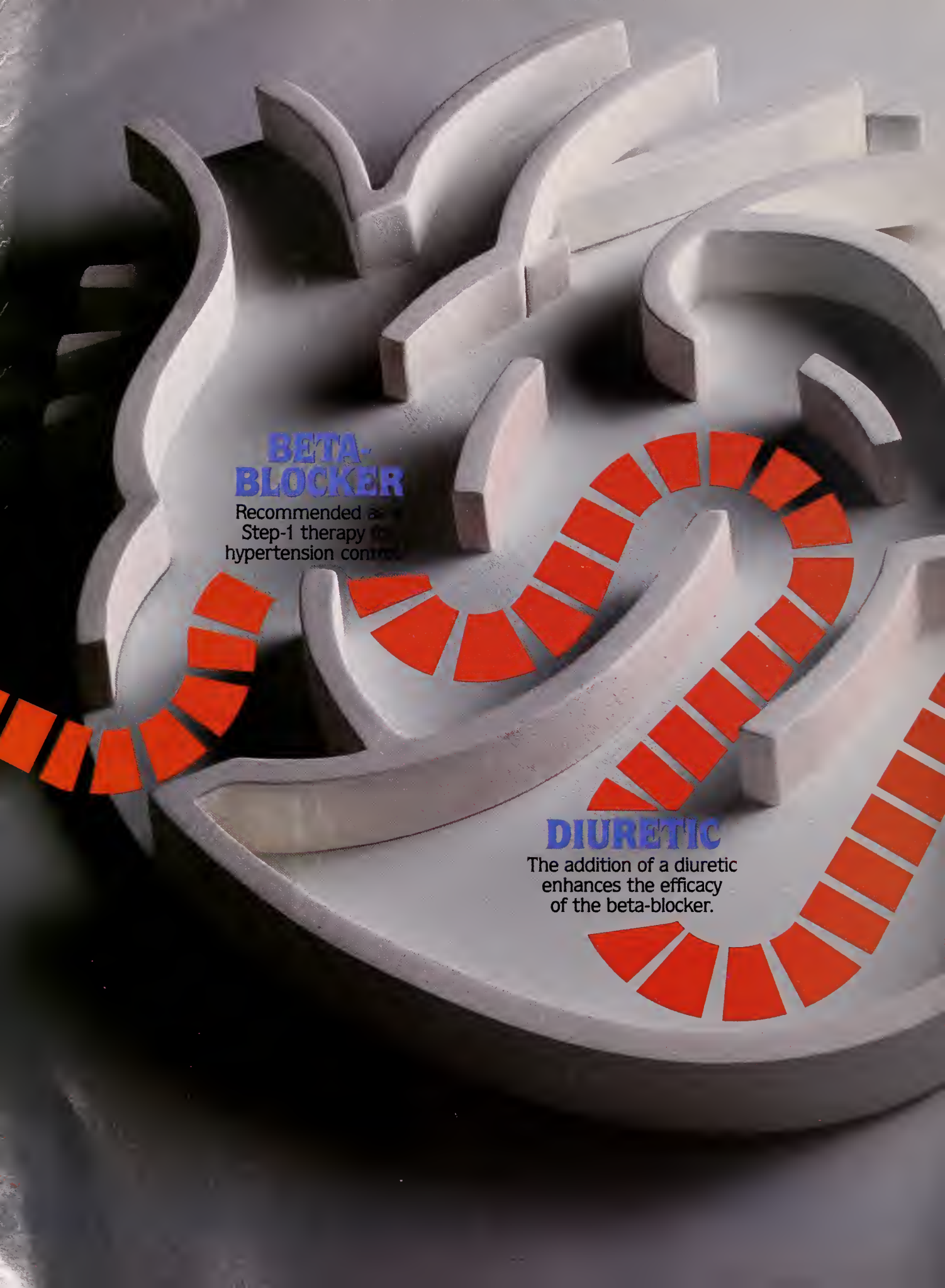
Issued 4/1/84

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

The Logical Path to Compliance




BETA-
BLOCKER
Recommended as
Step-1 therapy
hypertension
DIURETIC
The addition of a diuretic
enhances the efficacy
of the beta-blocker.

IN HYPERTENSION END POINT:

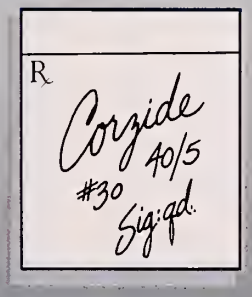
CONTROL, COMPLIANCE, CONVENIENCE

When hypertension control is complicated by the need for a beta-blocker plus a thiazide, CORZIDE® simplifies patient compliance with reliable once-a-day dosing in a single tablet.

CORZIDE®

(nadolol-bendroflumethiazide tablets)

Makes good sense



SQUIBB

Innovators in cardiovascular medicine

*Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure: The 1984 report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure. Arch Intern Med 144:1045-1057, 1984.

Please see brief summary of prescribing information on following page

CORZIDE®

(nadolol-bendroflumethiazide tablets)

CORZIDE® 40/5
CORZIDE® 80/5
Nadolol-Bendroflumethiazide Tablets

DESCRIPTION: CORZIDE (Nadolol-Bendroflumethiazide Tablets) for oral administration combines two antihypertensive agents: CORGARD® (nadolol), a nonselective beta-adrenergic blocking agent, and NATURETIN® (bendroflumethiazide), a thiazide diuretic-antihypertensive. Formulations: 40 mg and 80 mg nadolol per tablet combined with 5 mg bendroflumethiazide.

CONTRAINDICATIONS: Nadolol — Bronchial asthma, sinus bradycardia and greater than first degree conduction block, cardiogenic shock, and overt cardiac failure (see WARNINGS). **Bendroflumethiazide** — Anuria, and in those with previous hypersensitivity to bendroflumethiazide or other sulfonamide-derived drugs.

WARNINGS: Nadolol — Cardiac Failure — Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta-blockade may precipitate more severe failure. Although beta-blockers should be avoided in overt congestive heart failure, if necessary, they can be used with caution in patients with a history of failure who are well compensated, usually with digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle. IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta-blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, digitalize and/or give diuretics, and closely observe response, or discontinue nadolol (gradually, if possible).

Exacerbation of Ischemic Heart Disease Following Abrupt Withdrawal — Hypersensitivity to catecholamines has been observed in patients withdrawn from beta-blocker therapy; exacerbation of angina and, in some cases, myocardial infarction have occurred after *abrupt* discontinuation of such therapy. When discontinuing chronic use of nadolol, particularly in patients with ischemic heart disease, gradually reduce dosage over a 1- to 2-week period and carefully monitor the patient. Reinstitute nadolol promptly (at least temporarily) and take other measures appropriate for management of unstable angina if angina markedly worsens or acute coronary insufficiency develops. Warn patients not to interrupt or discontinue therapy without physician's advice. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue nadolol therapy abruptly even in patients treated only for hypertension.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA-BLOCKERS. Administer nadolol with caution since it may block bronchodilation produced by endogenous or exogenous catecholamine stimulation of $beta_2$ receptors. **Major Surgery** — Because beta blockade impairs the ability of the heart to respond to reflex stimuli and may increase the risks of general anesthesia and surgical procedures, resulting in protracted hypotension or low cardiac output, it has generally been suggested that such therapy should be withdrawn several days prior to surgery. Recognition of the increased sensitivity to catecholamines of patients recently withdrawn from beta-blocker therapy, however, has made this recommendation controversial. If possible, withdraw beta-blockers well before surgery takes place. In emergency surgery, inform the anesthesiologist that the patient is on beta-blocker therapy. Use of beta-receptor agonists such as isoproterenol, dopamine, dobutamine, or levarterenol can reverse the effects of nadolol. Difficulty in restarting and maintaining the heart beat has also been reported with beta-adrenergic receptor blocking agents. **Diabetes and Hypoglycemia** — Beta-adrenergic blockade may prevent the appearance of premonitory signs and symptoms (e.g., tachycardia and blood pressure changes) of acute hypoglycemia. This is especially important with labile diabetics. Beta-blockade also reduces release of insulin in response to hyperglycemia; therefore, it may be necessary to adjust dose of antidiabetic drugs. **Thyrotoxicosis** — Beta-adrenergic blockade may mask certain clinical signs (e.g., tachycardia) of hyperthyroidism. To avoid abrupt withdrawal of beta-adrenergic blockade which might precipitate a thyroid storm, carefully manage patients suspected of developing thyrotoxicosis.

Bendroflumethiazide — Use with caution in severe renal disease. In patients with renal disease, azotemia may be precipitated. With impaired renal function, effects of the drug may be cumulative. Use with caution in impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS: General — Nadolol — Use with caution in patients with impaired hepatic or renal function (see DOSAGE AND ADMINISTRATION).

Bendroflumethiazide — At appropriate intervals, perform serum electrolytes determination to detect possible electrolyte imbalance warning signs of which are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and G.I. disturbances such as nausea and vomiting. Observe patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Drugs such as digitalis may influence serum electrolytes. Hypokalemia may develop, especially with brisk diuresis, in presence of severe cirrhosis. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Response of the heart to toxic effects of digitalis can be exaggerated with hypokalemia. Use potassium supplements such as high potassium foods to avoid or treat hypokalemia. Any chloride deficit is generally mild and usually does not require specific therapy except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than salt administration except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain thiazide-treated patients. Latent diabetes mellitus may become manifest during thiazide therapy. Antihypertensive effects of bendroflumethiazide may be enhanced in the postsympathectomy patient.

Careful reappraisal of therapy and consideration given to withholding or stopping diuretic therapy is necessary if rising nonprotein nitrogen or BUN (indicative of progressive renal impairment) occurs. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Thiazides decrease calcium excretion. Pathologic changes in parathyroid gland with hypercalcemia and hypophosphatemia have been occasionally observed with prolonged therapy. Common complications of hyperparathyroidism have not been seen.

Information for Patients — Warn patients, especially those with evidence of coronary artery insufficiency, against interruption or discontinuation of nadolol without physician's advice. Although cardiac failure rarely occurs in properly selected patients, advise patients being treated with beta-adrenergic blocking agents to consult physician at the first sign or symptom of impending failure. Advise patients of proper course if dose inadvertently missed.

Laboratory Tests — Regularly monitor serum and urine electrolyte levels (see WARNINGS, *Bendroflumethiazide*, and PRECAUTIONS, *General, Bendroflumethiazide*).

Drug Interactions — Nadolol — When administered concurrently the following drugs may interact with beta-adrenergic blocking agents: **Anesthetics, general** — exaggeration of anesthetic-induced hypotension (see WARNINGS, *Nadolol, Major Surgery*). **Antidiabetic drugs (oral agents and insulin)** — hypoglycemia or hyperglycemia; adjust antidiabetic drug dosage accordingly (see WARNINGS, *Nadolol, Diabetes and Hypoglycemia*). **Catecholamine-depleting drugs (e.g., reserpine)** — additive effect, monitor closely for evidence of hypotension and/or excessive bradycardia.

Bendroflumethiazide — When administered concurrently the following drugs may interact with thiazide diuretics: **Alcohol, barbiturates, or narcotics** — may potentiate orthostatic hypotension. **Antidiabetic drugs (oral agents and insulin)** — thiazide-induced hyperglycemia may require adjustment of antidiabetic drug dosage. **Other antihypertensive drugs** — additive or potentiated effect. **Corticosteroids, ACTH** — intensified electrolyte depletion, particularly hypokalemia. **Ganglionic or peripheral adrenergic blocking drugs** — potentiated effect. **Preanesthetic and anesthetic agents** — effects may be potentiated, adjust dosage accordingly. **Pressor amines (e.g., norepinephrine)** — possible decrease response but not sufficient to preclude their use. **Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)** — possible increased response.

Drug/Laboratory Test Interactions — Discontinue thiazides before tests for parathyroid function (see PRECAUTIONS, *General, Bendroflumethiazide*).

Carcinoganasis, Mutaganesis, Impairment of Fertility — Nadolol — In 1 to 2 years oral toxicologic studies in mice, rats, and dogs, nadolol did not produce significant toxic effects. In 2-year oral carcinogenic studies in rats and mice, nadolol did not produce neoplastic, preneoplastic, or nonneoplastic pathologic lesions. **Bendroflumethiazide** — Long-term studies in animals have not been performed.

Pregnancy — Teratogenic Effects — Nadolol — Category C. In animal reproduction studies with nadolol, evidence of embryo- and fetotoxicity was found in rabbits, but not in rats or hamsters, at doses 5 to 10 times greater (on a mg/kg basis) than the maximum indicated human dose; no teratogenic potential was seen in any of these species. There are no well-controlled studies in pregnant women, therefore, use nadolol in pregnant women only if potential benefit justifies potential risk to the fetus. **Bendroflumethiazide** — Category C. Animal reproduction studies have not been conducted. This drug's effect on the fetus when administered to a pregnant woman or its effect on reproductive capacity is not known. Bendroflumethiazide should be given to a pregnant woman only if clearly needed. **Nonteratogenic Effects** — Since thiazides cross the placental barrier and appear in cord blood, weigh anticipated benefit of the drug in pregnant women against possible hazards to the fetus; these hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other reactions which have occurred in adults.

Nursing Mothers — Both nadolol and bendroflumethiazide are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants either discontinue nursing or discontinue therapy, taking into account the importance of CORZIDE (Nadolol-Bendroflumethiazide Tablets) to the mother.

Pediatric Use — Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Nadolol — Most adverse effects have been mild and transient and have rarely required nadolol withdrawal. **Cardiovascular** — Bradycardia with heart rates of less than 60 beats per minute occurs commonly, and heart rates below 40 beats per minute and/or symptomatic bradycardia were seen in about 2 of 100 patients. Symptoms of peripheral vascular insufficiency, usually of the Raynaud type, have occurred in approximately 2 of 100 patients. Cardiac failure, hypotension, and rhythm/conduction disturbances have each occurred in about 1 of 100 patients. Single instances of first degree and third degree heart block have been reported, intensification of AV block is a known effect of beta-blockers (see also CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS). **Central Nervous System** — Dizziness or fatigue reported in approximately 2 of 100 patients; paresthesias, sedation, and change in behavior reported in approximately 6 of 1000 patients. **Respiratory** — Bronchospasm reported in approximately 1 of 1000 patients (see CONTRAINDICATIONS and WARNINGS). **Gastrointestinal** — Nausea, diarrhea, abdominal discomfort, constipation, vomiting, indigestion, anorexia, bloating, and flatulence each reported in 1 to 5 of 1000 patients. **Miscellaneous** — Each of the following reported in 1 to 5 of 1000 patients: rash, pruritus, headache, dry mouth, eyes, or skin; impotence or decreased libido; facial swelling, weight gain, slurred speech, cough; nasal stuffiness; sweating, tinnitus; blurred vision. Although relationship to drug usage is not clear, sleep disturbances have been reported. The oculomucocutaneous syndrome associated with practolol has not been reported with nadolol. The following adverse reactions may also occur. **Central Nervous System** — reversible mental depression progressing to catatonia, visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability with slightly clouded sensorium, decreased performance on neuropsychometrics. **Gastrointestinal** — mesenteric arterial thrombosis, ischemic colitis. **Hematologic** — agranulocytosis; thrombocytopenic or nonthrombocytopenic purpura. **Allergic** — fever combined with aching and sore throat; laryngospasm; respiratory distress. **Miscellaneous** — reversible alopecia, Peyronie's disease; erythematous rash, arterial insufficiency.

Bendroflumethiazide — Gastrointestinal System — anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis. **Central Nervous System** — dizziness, vertigo, paresthesia, headache, xanthopsia. **Hematologic** — leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. **Dermatologic-Hypersensitivity** — purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis). **Cardiovascular** — orthostatic hypotension may occur. **Other** — hyperglycemia, glycosuria, occasional metabolic acidosis in diabetics, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

OVERDOSAGE: Nadolol may cause excessive bradycardia, cardiac failure, hypotension, or bronchospasm if overdosed. Overdosage of thiazides may cause lethargy, which may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function and without evidence of serum electrolyte changes or dehydration. Gastrointestinal irritation and hypermotility may occur. Transitory increase in BUN and serum electrolyte changes may occur, especially in patients with renal impairment.

Treatment — Nadolol can be removed from the general circulation by hemodialysis. In determining duration of corrective therapy, take note of the long duration of the effect of nadolol. In addition to gastric lavage, employ the following measures, as appropriate. **Excessive Bradycardia** — Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **Cardiac Failure** — Administer a digitalis glycoside and diuretic. It has been reported that glucagon may also be useful in this situation. **Hypotension** — Administer vasopressors, e.g., epinephrine or levarterenol. (There is evidence that epinephrine may be the drug of choice.) **Bronchospasm** — Administer a $beta_2$-stimulating agent and/or a theophylline derivative. **Stupor or Coma** — Supportive therapy as warranted. **Gastrointestinal Effects** — Symptomatic treatment as needed. **BUN and/or Serum Electrolyte Abnormalities** — Institute supportive measures as required to maintain hydration, electrolyte balance, respiration, and cardiovascular and renal function.

DOSAGE AND ADMINISTRATION: DOSAGE MUST BE INDIVIDUALIZED. Patients with renal failure require adjustment in dosing interval; see package insert for dosage in these patients.

Consult package insert before prescribing CORZIDE (Nadolol-Bendroflumethiazide Tablets).

HOW SUPPLIED: Available as scored tablets containing 40 mg nadolol combined with 5 mg bendroflumethiazide and 80 mg nadolol combined with 5 mg bendroflumethiazide in bottles of 100.

© 1986 E. R. Squibb & Sons, Inc., Princeton, NJ 08540
506-504 Issued: February 1986

FAMILY PHYSICIANS—GENERAL SURGEONS—INTERNISTS

Why, How and When?

flexible sigmoidoscopy

A 1½ day post graduate course and workshop

- *ACCREDITATION:* Applied for 10½ hrs. credit; Category 1, AMA, and Prescribed credit.
- *SPONSOR:* Medical Education Foundation of Miami
- *CO-SPONSORS:* South Miami Hospital, Florida Gastroenterologic Society
- *COURSE DIRECTOR:* John P. Christie, M.D.
- *REGISTRATION FEE:* $225.00 (Syllabus and luncheon included)

Sat./Sun., Apr. 19-20, or Nov. 15-16, 1986

Sonesta Beach Hotel and Tennis Club

For information, write to:
6614 Miami Lakes Drive East
Miami Lakes, Florida
(305) 687-1367

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral

Methyltestosterone U.S.P. Tablets

ANDROID®/F

Fluoxymesterone U.S.P. Tablets, 10 mg.





THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

FEBRUARY 1986 Vol. 73, No. 2

CONTENTS

SCIENTIFIC ARTICLES

Arthur E. Pitchenik, M.D., Thomas J. Spira, M.D., and Eugene R. Schiff, M.D. **107** Acquired Immunodeficiency Syndrome (AIDS) associated with blood transfusion: review of literature and report of two cases from Dominican Republic and Haiti

C. Richard Conti, M.D., Daniel R. Salomon, M.D., and Michael J. Carmichael, M.D. **111** Cardiac transplantation

Gabriel Mayer, M.D., Meredith Scott, M.D. and Michael Nocero, M.D. **114** Thymoma associated with Lupus syndrome and associated findings of pulmonary sequestration

SPECIAL ARTICLE

Richard J. Feinstein, M.D. **119** Changing the rules

COVER

This month's cover of *The Journal* is a scratchboard rendering by Jacksonville artist James B. Upright. The cover illustrates the lead scientific article dealing with AIDS associated with blood transfusions.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida Address: *The Journal of the Florida Medical Association, Inc.*, [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204 Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc are not responsible for the opinions and statements of its contributors and advertisers Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Forida Medical Association, Inc.

DEPARTMENTS

93 President's Page
April 21st — A day in the right direction

95 Editorials
Quality of care in jeopardy
R.G. Lacsamana, M.D.
An invitation to *Journal* readers
R.G. Lacsamana, M.D.

99 Letters & Viewpoints

123 Medical Economics
Should Florida physicians embrace medical trade unions?
Why we need medical unionism
Thomas E. Scott Jr., M.D.
Unionism: an inappropriate treatment for medicine's ills
Jacques R. Caldwell, M.D.

129 Notes & News

131 Dean's Message

132 Encores!

134 Scam of the Month

137 FMA Auxiliary
Chemical dependency
Mrs. Clifford B. (Nancy) Miles

140 Deaths

144 Meetings

148 Classified Advertising

154 Index to Advertisers

154 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

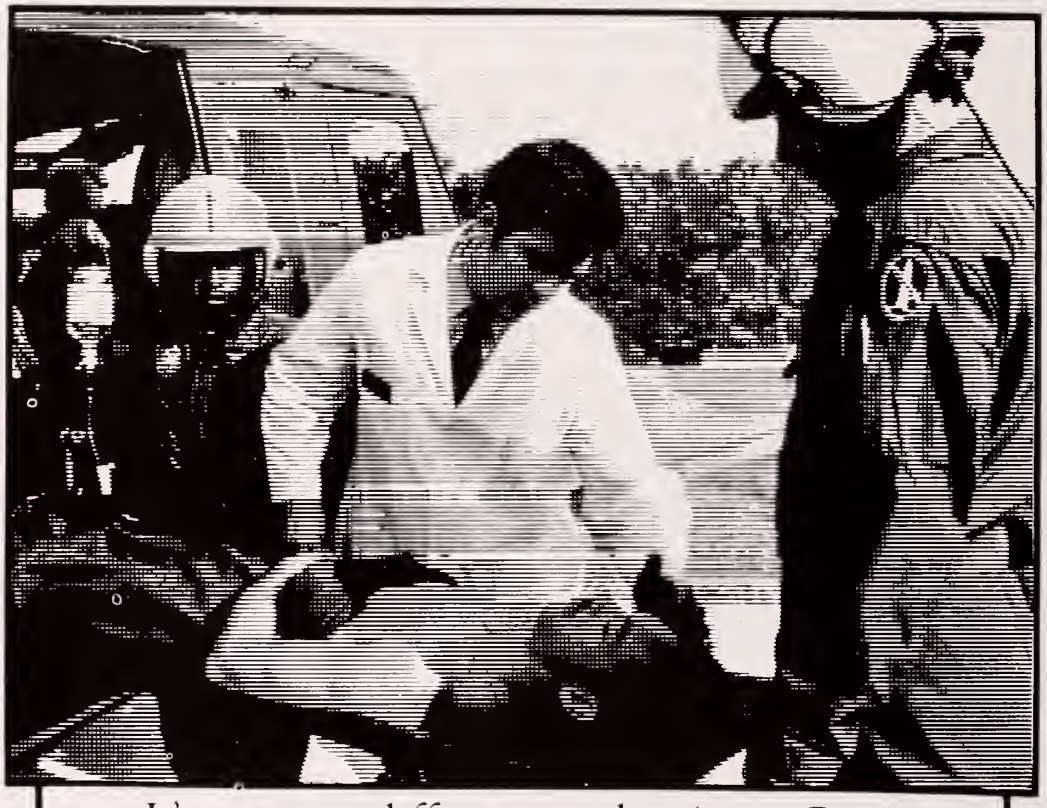
Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting
Editorial Staff:
Karl M. Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, MD..
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.

PHYSICIANS, A WEEKEND WITH THE RESERVE ISN'T JUST ANOTHER DAY AT THE OFFICE.



It's not just different in the Army Reserve, there are opportunities to explore other phases of medicine, to add knowledge, and to develop important administrative skills. There are enough different needs to fill right in your local Army Reserve unit to make a weekend a month exciting and rewarding.

Explore the possibilities. Call our officer counselor:

(North Florida)
CPT WINOKUR, MSC
(305) 896-4930/4793 COLLECT
USAR AMEDD PROCUREMENT
3101 MAGUIRE BLVD., SUITE 166
ORLANDO, FL 32803

(South Florida)
CPT WALTER DAVIS, MSC
(305) 667-5600/5609
USAR AMEDD PROCUREMENT
SUITE 207, 5900 S.W. 73RD STREET
MIAMI, FL 33143

ARMY RESERVE. BE ALL YOU CAN BE.

Medical Alert

Do You Know This Vital Sign?

To professionals in medicine and pharmacy, this is the mark of a distinguished member of the healthcare community—the Certified Medical Representative.

This achievement recognizes the successful completion of hundreds of advanced home-study hours in pharmacology, physiology, microbiology and other medically-related courses. Followed by rigorous examinations at one of 50 major universities throughout the country. And course work that has been accredited by the American Council on Education, and approved by The American Council on Pharmaceutical Education.

So you can be certain CMR's display the vital signs of the medical professionals they serve: dedication and determination, knowledge and understanding, competence and consideration.

Write or call for a free catalog and complete details today.

Know Your CMR

The Certified Medical Representatives Institute, Inc.

4316 Brambleton Avenue, S.W., Dept. SFL 2-6
Roanoke, Virginia 24018
703/989-4596



The appearance of these tablets is a registered trademark of Wyeth Laboratories

DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia, some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV) **for Anxiety** (lorazepam)

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

Wyeth Laboratories
Philadelphia, PA 19101

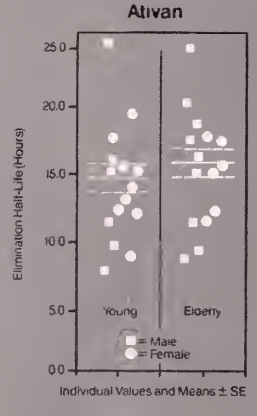
In addition to effective relief of anxiety associated with depressive symptoms...

Only Ativan® (lorazepam) CIV

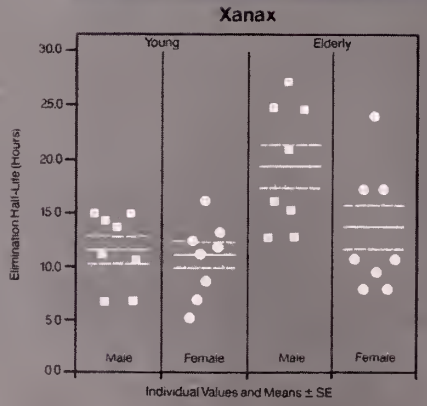
among leading benzodiazepines, has proof that its pharmacokinetics are not significantly altered by age.[1]

With Ativan, elimination half-life was very similar between young and elderly groups tested; differences did not approach statistical significance.[1]

Comparison of elimination half-lives in young and elderly subjects.



Ativan® (lorazepam)[2]
Ativan®, which is *conjugated* rather than oxidized, shows little difference in half-life (t ½) between young and elderly subjects.



Xanax® (alprazolam)[3] CIV
Xanax® requires *oxidative* (P450) metabolism; significant differences in half-life are shown between young and elderly male subjects; half-life is minimally influenced by age in women.

References:
1. Greenblatt DJ: Clinical study, pharmacokinetics and bioavailability in the elderly, Ativan® (lorazepam). Data on file, Wyeth Laboratories.
2. Greenblatt DJ, Allen MD, Locniskar A, et al: Lorazepam kinetics in the elderly. Clin Pharmacol Ther 26:103, 1979.
3. Greenblatt DJ, Divoll M, Abernethy DR, et al Alprazolam kinetics in the elderly. Arch Gen Psychiatry 40:287, 1983.

Wyeth Laboratories
Philadelphia, PA 19101

See important information on preceding page.

© 1985, Wyeth Laboratories.

April 21st — A day in the right direction



On Monday the 21st of April, the physicians of Florida and their spouses will assemble in Tallahassee to emphasize the liability crisis we are confronting in the state. We hope to be joined by representatives from all segments of business and industry who are now reeling under the same liability crisis that has been plaguing physicians for 10 years.

This is not going to be a rowdy assembly, but only to call to the attention of our legislative representatives the rapidly escalating problems of affordability and availability we are confronting, along with every business or profession in the state in regards to liability insurance.

We will assemble in the Civic Center in Tallahassee and designate small groups to visit each legislator in the morning and afternoon: appointments will be made with their offices in advance to be sure of their availability, at which time, we will be able to meet with them in a more tranquil environment, to reason with them and try to obtain their help for our just cause.

Buses will be available at the airport for those arriving by plane. Transportation to and from the Civic Center to the Capital will be available for those who have appointments to talk to their Representatives.

A luncheon will be organized and every legislator will be invited to attend and join with the people of their district. At this time we can also talk with them about our issues and the justice of these issues.

The issues to be covered are: 1) A $250,000 cap on non-economical damages; this is the amount approved in California and ratified by the Supreme Court of the U.S. as reasonable. Studies indicate that a cap would result in a savings in premiums of between 15% to 20%.

2) Abolition of mandatory insurance linked to licensure. This is morally wrong. We are not physicians because we have insurance, we are physicians beeause we graduated from a university sehool of medicine, did our training and proved our profieieney in the Art of Medicine, and have taken several examinations and tests in the course of our career to show this achievement.

On the other hand, it is morally wrong to deprive a semi-retired physician or a part-time physician, with no hospital privileges to be unable to eontinue practicing their profession, even in a limited form, because he or she cannot afford the high premium for insurance.

We are aware of and readily accept our financial responsibility to the real injury cases. We do not want this eliminated for our own sake or that of our families, but to carry this to the extreme is unjust and illogical, since the ultimate losers are going to be the people of Florida, deprived of the services provided now by those physicians.

3) We are asking for modifications of the joint and several liability doctrine by which a minimally responsible party has to assume the whole of the award if the other party cannot fulfill his obligations.

This is the basis of the "deep pocket" theory by which every possible party is included in the suit,

regardless of how much contribution to the damage can be directly allocated to each one of them in the hope that the total of the award, if any, will be collected.

Our task is not going to be easy, and we have to talk with the legislators in convincing and logical tones. We have to make them realize that because of the liability crisis we are facing, the practice of medicine in Florida, which is at par with all the States in the U.S., and the best medical care system in the world, is in danger of crumbling and our citizens soon will be deprived of the most advanced but risky procedures that are attempted only by the best doctors in the communities in which we live. The scope of the crisis is such that it extends to an entire free enterprize system.

Let us all go to Tallahassee, (leaving the necessary number of physicians to maintain an adequate level of care in our respective cities) on April 21st, so that ladies and gentlemen alike shall sit down with our legislators and reason together.



Quality of care in jeopardy

The excellence of American medicine is well known throughout the world. Over the last three decades, American physicians have been at the cutting edge of every modern medical advance, whether this be in basic research, discovery of new drugs, application of new vaccines, introduction of new surgical techniques, or the use of new technology. Patients are the ultimate beneficiaries of these advances. Americans get the best medical care in the world, and it makes little difference whether they live in the rural areas or in big urban centers.

But there is increasing concern that the high quality of medical care in this country may be eroded by drastic changes that have altered the medical landscape within the past ten years. Physicians are now practicing their profession under an onerous burden of bureaucratic and fiscal restraints and under a system that has diluted their power, while patients are finding themselves the victims of a new culture that values economy over excellence. A pervasive atmosphere of runaway litigation only tends to exacerbate the problem.

Of the many changes that have affected medical practice, there are two principal forces that are clearly eroding the standards of care: competition and cost control. They may have curbed the cost of medical care to a certain extent, but they have also spawned a spate of problems the adverse effects of which are starting to surface.

Competition as an instrument of national health policy was born in the early '70s in an attempt to tone down the spiralling costs in medical care. The assumption then was that competition would bring out the best in our health care system, make it easy for Americans to shop for their medical care, and at the same time make it cheaper for everybody. But it has not worked out that way so far. What originally was designed to permit the creation of different competing systems for delivery of medical care has gradually metamorphosed into a free-for-all that has allowed the entry of so-called alternative medical care along with non-physician practitioners of different colors and persuasions. In recent years, wave upon wave of allied medical personnel as well as a contingent of quasi-medical practitioners started agitating for privileges to practice independently, alongside physicians, and partake of the grand feast at the medical table. Mainly through legislative fiat, some of them have succeeded, some are still knocking at the door, while a few have even gained a patina of legitimacy where they could not do so previously on their own merit. The case of optometrists, advanced nurse practitioners, clinical psychologists, and a few other pretenders to practice medicine is a classic example of what has been taking place. The intense lobbying efforts by these groups from year to year in state legislatures mirror the rush to join the medical bandwagon unleashed by competition.

It is a grand paradox that at a time when Americans demand the best medical care, our politicians find it convenient to dispense favors to a bunch of unqualified impostors. The charge that physicians are trying to perpetuate a monopoly by keeping out everybody else is a blatant smokescreen. The main issue here is whether these non-physician practitioners are qualified by education, training, and experience to practice medicine. The case of Florida pharmacists, recently sanctified to practice part-time medicine by a gracious legislature, comes to mind. Pharmacists may have spent four years studying and dispensing drugs, but that does not qualify them to practice medicine like physicians, who have had far more extensive training beyond pharmacology and therapeutics. The same can be said for physicians'

assistants, midwives, advanced nursc practitioners, and a host of other go-getters who are all anxiously waiting for their turns. It is indeed strange that other professionals like lawyers, accountants, and engineers would not tolerate poaching by other people in their territories; why should we in medicine? Remember Rosemary Furman who was chased all the way to the Supreme Court by the Florida lawyers? Maybe we ought to do the same.

Regardless of the bleeding hearts of our legislators, the entry of non-physician practitioners in medicine is a sure sign that the decline in the standards of medical care is going to accelerate.

Competition has bred another evil: it has spawned the commercialization of medical practice. Everybody is scrambling for economic survival, whatever that means, with the danger that in so doing we may forget that our primary business is the welfare of the patient, not our pocketbook. Consider commercialized medical practice on a grander scale: corporate medicine. Corporations have become well entrenched in medicine and have been cutting swaths in medical practice unparalleled in the history of the medical profession. The profit motive of course is what drives corporate medicine, and the debate continues on whether the profit motive and good medical care can ever be compatible.

What about cost control in medicine? While there is no question that curbs were needed to control the spiralling costs of medical care, the draconian measures applied by the government — mainly through the imposition of the DRG system — have raised questions in the medical community and recently in Congress about the potential deleterious effects on the care of the elderly. It is beguiling to read that the rate of hospital admissions for Medicare patients is down and that Medicare spending has slowed down; at the same time, reports are sprouting nationwide of patients being discharged prematurely and then readmitted, of physicians being pressured to discharge their Medicare patients as soon as possible, of hospitals greasing the palms of certain physicians for packing their patients in and then packing them out, and of the professional review organizations being derelict in reviewing the abuses of the DRG system. The report by Senator John Heinz issued in September 1985 to the Senate Special Committee on Aging concerning the flaws of the DRG system, where the term "quicker and sicker" has become a stock monicker, is the first official harbinger from the government that something is remiss somewhere.

Controlling costs and maintaining the high quality of medical care are not necessarily incompatible, but they can be compatible only up to a certain point. The cookbook approach mandated by DRGs imposes too many constraints on physicians. Furthermore, this approach ignores the fact that human illness cannot be programmed to respond according to DRG blips, casting doubts on whether quicker hospital care is necessarily better care. If anything, DRGs have been a boon to hospitals' coffers, but a big question mark as far as patient care is concerned.

The dual threats posed by competition and cost control should wake up physicians to the reality that medical care in this country may slip to second-rate. By allowing the encroachment of medicine by unqualified practitioners, by encouraging the commercialization of medical practice, and by approaching the care of elderly people primarily on the basis of costs, these twin forces have placed physicians in a position where they are no longer in control of their profession. This loss of control means that we are in a deep hole, and it can only get deeper unless we do something to reverse the trend.

But can something be done to salvage excellence and to regain control of our profession? Given the precarious positions physicians find themselves in and the mounting pressures from the government and big business to control the direction of medical care, many physicians think it is quixotic at best to perceive that we can ever turn the tide. But that is a defeatist attitude. We ought to proceed from the premise that excellence in medical care is what our patients want, that preserving it is worth fighting for, and that physicians should be calling the shots, not anybody else. Vigilance, militancy, and above all, unity, as the president of the FMA has repeatedly stressed, are what we need in our quest for what we have lost.

How well we stand together to preserve the best of our profession will determine whether excellence as an ideal in medicine is a thing of the past, or as a heritage we can bestow to future generations of patients and physicians.

R. G. Lacsamana, M.D.
Editor

An invitation to Journal readers

One of the functions of a modern medical journal, apart from being a vehicle of scientific information, is to serve as a forum for discussion of those issues that affect medicine. It is with this editorial philosophy that I took over the reins of *The Journal of the FMA* ten months ago. At a time of ferment in medicine, when so many drastic changes are taking place, the role of *The Journal* in exploring the broad spectrum of issues confronting physicians becomes even more important. To that end, we from the editorial staff have introduced a number of changes to accomodate the expanded role of *The Journal.*

Among other things, we have recast the editorial page to include two or more editorials per issue, usually focusing on those things critically impinging on the medical profession and physicians. The new variety of editorial flavor now being served, which is a product of varying viewpoints and perspectives from the editorial staff, has been palatable so far to most *Journal* readers. In addition, we have created a new section, Letters and Viewpoints, which, in many ways, is like an Op-Ed page, but written usually from the vantage point of the readers. This section has created an additional avenue for physicians to sound off, argue a point with *Journal* authors, present some unique experience, or occasionally just bitch about something. Because of the emerging importance of medical economics, we have also created a section devoted to this topic in its many dimensions, edited by an erudite and perceptive observer of the economic scene. Last but not least, we have continued the practice of reprinting in *The Journal* two or three commentaries on various subjects, culled from other journals, to give readers an eclectic view of what is happening in medicine.

We are pleased with what we have done, and it is safe to say that most *Journal* readers are equally pleased with the changes. But our job is far from over. The continued vigor and future good health of *The Journal* will depend on the commitment and participation of all physicians. The pages of *The Journal* are open to everybody, and we extend an invitation to all readers to contribute their pieces. We welcome all kinds of contributions — whether these are scientific papers, case reports, commentaries, serious discourses, letters, or what have you — just as long as they have a bearing on medicine and have an important point, message, or lesson to deliver to physicians. Most successful medical journals like the *New England Journal of Medicine* and the *Lancet* have succeeded because their readers made them so with their enthusiastic support. While we have no aspirations to scale the heights that these journals have reached, we at least will try to make our state medical journal as good as it can possibly be.

Most physicians are diffident about sending contributions because they are either busy or do not have any experience in writing. We know, we know; we have heard the same excuse many times before. But physicians who serve on the state and county medical societies are also busy and yet have never offered that as an excuse to shy away from what needs to be done. The second excuse — that of lack of writing experience — may be more valid to a lot of physicians but should not serve as an impediment to try. A number of us on the editorial staff have had no previous professional writing experience but somehow have managed to learn the basic rudiments. The ingredients are simple: a good working knowledge of the English language, a good and interesting topic, and an ability to express one's thoughts clearly and accurately. So for those of our readers who have always wanted to write but were afraid to, now is the time to try and to get down on paper those

thoughts that have been burning in your minds.

If, having considered our invitation, one decides to submit an article to *The Journal*, the next logical question is: what are the chances of an article being accepted for publication? There is no pat answer but the chances of acceptance obviously are proportional to the quality of the article. If figures mean anything, the acceptance rate for the past one year has been around 40% to 50%. Those are pretty good odds. A rejection slip should not be taken as a blow to one's pride or ego; the best-published authors know that rejection slips are a routine part of the business.

Most articles submitted to *The Journal*, particularly scientific papers and those dealing with sensitive and controversial issues, are reviewed rigorously by three to six physicians drawn from a panel of consulting editors, all with expertise in their fields, and from members of the editorial staff. Based on the reviews and comments of these physicians, the editor then decides on what to accept and to reject. The final decision to accept or reject, therefore, is a synthesis of the judgments of many physicians. A good paper that is accepted for publication usually appears in print two to four months after submission, occasionally longer; a paper that needs revision, on the other hand, takes a little longer.

With this invitation to our readers, we hope to stimulate new infusions of talents, insights, and perspectives into the pages of *The Journal*. We look forward to your contributions.

R. G. Lacsamana, M.D.
Editor

20 YEARS OF CONFIDENCE

Thank you for your loyal support



DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

SK&F CO.

Everybody deserves a chance to make it on their own.



Everybody.



The National Urban League is dedicated to achieving equal opportunity for all. And you can help. Contact your local Urban League or write:

National Urban League
500 East 62nd Street
New York, N.Y. 10021

Ad Council A Public Service of This Publication

No more free rides

It is becoming more frequent each year to find physicians resigning from organized medicine at one level or another. The common reason is "I am not gaining anything by being a member."

I believe firmly that we as dedicated members of organized medicine, especially those of us who are members of the total federation, must become involved actively in speaking out against the actions of our colleagues who choose to become nonmembers. We have been considerate far too long to not rise to the occasion now and to illustrate exactly what is happening when these physicians leave the fold.

The common excuses offered for leaving are absolute untruths. Our country is abundant with many nonphysicians who are working to destroy the integrity of our profession, slowly but surely. Let us wake up and realize that the brothers of our own profession are joining these "others" in their denial to serve the profession by membership in the federation. Surreptitiously they are part of the effort to lessen our free society and to assist its slow erosion into a socialist state. Since membership is not obligatory, they blame the organization for doing nothing for them. Yet they do not admit that they have done nothing for the organization. There is no group anywhere from which the members benefit if they do not contribute.

There have always been individuals who choose to sit back and reap the benefits derived from the work and risks taken by others. This is true in medicine — the non-members of the federation doing nothing for the cause, yet benefitting in every way from the efforts of those who actively participate.

The time is right for each of us to speak out against those of our profession who join the efforts of others to destroy us. Self-preservation is our goal and it will not be achieved unless each one assumes his responsibility to stand up and be counted, to speak out for the good of our profession. The time is now to get our show on the road. Organized medicine is growing weary from the weight of those who choose not to participate. They deserve no more free rides.

Robert E. Windom, M.D.
Sarasota

Fumes from a non-smoker

Your editorial in the December issue on cigarette smoking has created within me an ambivalent response. On the one hand, I hear and feel you are justified in proposing that the public is responsible for its own health, and to be sure, I am appalled at the increasing use of the courts to solve our problems. However, on the other hand, when we critically explore the use of tobacco and its relationship to our society's health, I could certainly justify the use of the courts to attack what our government and the tobacco companies have failed to rectify.

In the face of insurmountable evidence, the tobacco companies have failed to respond in an ethical fashion. They for years have resisted all

public education efforts, using their power and influence, to persuade the media in this country to their viewpoint. They have not once voluntarily done anything to warn their victims of the dangers involved in the use of tobacco and, in addition, they have not participated in helping the farmers to modify their lands so that they can produce a new money crop. Their advertising efforts, in spite of rules and regulations to the contrary, continue to blatantly ignore the law. They sponsor such things as the Winston-500 NASCAR Series, the Virginia Slims Tennis Tournaments, knowing full well they are attracting our children to a habituation to their dangerous products. As a matter of fact, in the past year, they have doubled the amount of money used for advertisement in an effort to attract young people to their product. (It is known that advertisement primarily influences the new smoker rather than the old smoker.)

Our government has done blessed little to help in the cause. Senator Jesse Helms and his compatriots have a powerful hold over the Congress of the United States. The hold probably amounts to the fact that the tax base would be significantly affected if the cigarettes were withdrawn. It is known that cigarette tax increases have primarily affected the new smoker in that the increased taxes have been a deterrent to the initiation of smoking by our young people; yet, the president of our country has stated that it should be halved. Our government continues to subsidize our tobacco industry. I frequently hear that people ought to be allowed to smoke if they so desire, and I agree with that, but I do feel that they should pay the real price of a carton of cigarettes, and that real price is not eight or nine dollars, but truly $61.00 a carton if you take into account all of the expenditures associated with the production and manufacture of a carton of cigarettes.

I am sure I do not have to tell you that the use of tobacco is the bubonic plague of the 20th Century. Somewhere between 350,000 and 500,000 Americans will die of cigarette-induced diseases this year; not 1987, but 1986. There will be 123,000 new cases of lung cancer; 118,000 of these will die in 1986 (more people will die of lung cancer this year than died at the combined bombing of Hiroshima and Nagasaki). Lung cancer in women has surpassed breast cancer as a killer. It is now the leading cause of death, due to cancer, in women in the United States. Twenty cents out of every health care dollar, and twenty-five cents out of every hospital dollar, will be spent on cigarette-induced disease. The EPA has labeled tobacco smoke our most dangerous air pollution. Less than 30 percent of our population smokes. We have laws to protect our hearing, our food, our rivers, our car exhaust, but very few to protect us from tobacco smoke! Is this responsible government?

I agree that people need to take responsibility for their diseases. However, our government, in my opinion, has not acted in a morally correct fashion. It has not properly insured the public educational opportunities as to the real dangers, and it has certainly not placed the proper emphasis on the issue. The tobacco companies have certainly not acted in a moral or ethical fashion. They have continued to advertise their products, attempting to habituate young Americans to a product known to be dangerous to their health. If the government and the tobacco companies will not respond in a responsible fashion that best serves the interest of the public good, then we have no other option but to vigorously apply pressure on all fronts, including the courtroom. Tobacco companies are as culpable as the Manville Corporation in the asbestosis issue, and Robins in the Dalkon Shield. American business must act in a moral and ethically correct fashion, or, by God, they must pay the consequences. As far as I am concerned, the courts are a perfect place to attack them. We may not win in the courts, but at least the effort and the controversary will arouse and educate the public as to the true dangers. Americans will also recognize the extent of the disease and become informed of the massive numbers of our citizens dying of tobacco-induced diseases. They will also be informed of the onerous burden to the American health system and the taxing of its resources. The tobacco companies and our government have chosen a position contrary to the public good. Courts are places where adversaries meet to solve their problems. Let us have it!

Alvin E. Smith, M.D.
Ormond Beach

Editor's reply: As a non-smoker and civic-spirited physician, I cannot agree more with Dr. Smith about the evils of smoking and the need for the tobacco companies to be more honest in their advertising. Where he and I disagree is on the issue of who should be culpable when a smoker gets ill as a result of chronic and heavy smoking. The editorial that I wrote pounded on the point that an individual who smokes of his own volition, and aware of the hazards of smoking, should blame nobody but himself if he gets sick in the process. A court in California and another in Tennessee so far have sided with the tobacco companies against smokers who have filed suits against them.

Why not pass the buck?

RE: Cigarette smoking on trial, December issue, 1985, Vol. 72, No. 12.

In paragraph five of the above mentioned editorial you made the following comment: "Those

who want to smoke and enjoy it should do so; if they stay healthy, more power to them. If they get sick, that is their tough luck. But please, let us not pass the buck to somebody else."

If you will refer to the Bible, Judges chapter 21, verse 25, you will note the following: ". . .every man did what was right in his own eyes." The attitude exemplified in your paragraph five by you and others with the same mind-set is typical of the permissiveness in our nonthinking society today.

Many reasons exist for refuting your opinion as expressed in the editorial noted above. To name a few:

1. Some of the retarded persons were thus born because of mothers smoking during pregnancy; others were prematurely born with damaged brains, or were so weak they were susceptible to disease that damages their brain. "The buck's passed on to somebody else."

2. The cost for medical expenses (Medicare and insurance) to care for the poor victims of cancer, emphysema, coronary disease, etc., resulting from smoking, results in "the buck's passed on to somebody else."

3. When a younger family member sees a parent smoking, he or she is inclined to think "what my parents do is also good for me." "The buck is passed on to somebody else." Parents' examples teach.

4. The money wasted on smoking tobacco is enough to educate a number of promising youth.

5. God has given each one a body designed for a limited time. The least we can do is care for ourselves so we can accomplish the purpose for which we were created.

What I have said about smoking cigarettes is also applicable to other addictive drugs which injure the human body.

Your statement that "those who want to smoke and enjoy it should do so" is anything other than what a responsible physician should say to anyone, considering the injuries sustained thereby to the human body.

We as physicians are not acting responsibly if we do not do everything we can to improve the health of human beings.

Osmah Elias Harrell, M.D.
Jacksonville

Editor's reply: As with Dr. Smith, I agree with most of the points that Dr. Harrell articulated in his harangue on my editorial. I also would like to assure him that I consult the Bible periodically for inspiration and guidance. But I disagree with him vigorously that passing the buck to somebody else will end the problem of smoking and all its evils. It is philosophically unsound and legally wrong to espouse a system of values where an individual, in the voluntary exercise of an act which may be harmful, is excused of any responsibility. Physicians who preach the virtues of preventive medicine are making a mockery of what they tell their patients if they absolve them of their responsibilities and let others take the blame. Nothing ever works that way.

Allowing people to smoke if they want to may be permissive, but that is their own choice. Blame them if they get sick, not the tobacco companies.

Sure there are other substances like alcohol that are equally harmful to the body as tobacco. But I do not call a lawyer to sue Seagram's every time I have a hangover. Perhaps I better have my drink first before I get smoked out by this subject.

New ground for pharmacists

I enjoyed reading Dr. Richard Feinstein's contribution in the December issue of *The Journal* concerning recent legislation allowing pharmacists to prescribe certain drugs. I think it is important for everyone to understand that the real movers toward changing the role of pharmacists are located at the School of Pharmacy at the University of Florida. It is quite true that pharmacists who practice their profession in the communities of Florida are not willing to move into the high-risk field open to them by their recently passed legislation. However, the educators of pharmacists in our state university see the role of future pharmacists as that of clinical pharmacists. At the hearings before Rep. Kelly, I witnessed members of the faculty of the pharmacy school argue quite forcefully for this provision which will no doubt be expanded in the future, and of course, these guys who suffer from inferiority complexes at the medical school are all for creating a better self-image for themselves as educators of mini-doctors.

Rep. Kelly was simply doing their bidding, and I am sure these faculty members will be present in force at new hearings this year to expand the role of pharmacists and limit the role of doctors as providers of drugs as well as prescribers of same.

Joseph C. Webster, M.D.
Ocala

Editor's reply: Murphy once observed that one's life, liberty, and happiness are in danger when the legislature is in session. It is time once again to man the ramparts of our profession in Tallahassee before we have nothing left to defend from the unfriendly prowls of our legislators.

Needle aspiration of the breast: pros and cons

This is in reference to the article "Thin Needle Aspiration Biopsy as Diagonstic Tool: Community Hospital Experience", written by Jorge G. Arroyo, M.D. and Frank M. Taylor III, M.D., which appeared in the September 1985 issue of *The Journal.*

I am writing to you because needle aspiration biopsy for breast lesions is not indicated for the following reasons:

(1) If the aspiration biopsy is negative for malignancy, it is worthless.

Let us analyze the breast needle aspiration biopsies results: They had 302 breast cases out of 593 (breasts, lung, thyroid, etc.); approximately 50% of the cytology reports were benign, 9% were suspicious, 21% were malignant and 18% were unsatisfactory. So this is probably a selected group of patients where the clinician or surgeon wanted to rule out malignancy, but the authors had approximately 70% of the cases without open biopsy to prove otherwise malignancy, so it is presumable that this 70% who did not have the benefit of open biopsy had or have a significant percentage of malignancy. The argument under their point of view is correct if, when the aspiration biopsy is positive or suspicious, knife biopsy has to be done; but if it is negative, the physician cannot tell the patient she does not have cancer of the breast. The eclectic procedure is to do the open biopsy to rule out malignancy.

(2) I have just returned from the 11th World Congress of Obstetrics and Gynecology held in Berlin (West) on September 15, 1985. In Scandinavian countries, Sweden for example, physicians do not do aspiration biopsies of the breast but do open biopsies of the breast seven times more than we do in the United States, and the mortality rate for carcinoma of the breast is much less there because they are finding more early lesions such as the so-called carcinoma in situ of the breast.

(3) There is evidence that carcinoma of the breast is a slow growing tumor and can take up to 32 years to show up.

The majority of surgeons in the United States follow the guidelines of the American College of Surgeons about breast aspiration biopsy, and it is time to dispose of the needle aspiration biopsy of the breast lesions as a diagnostic tool.

Hernando L. del Castillo, M.D., F.A.C.O.G.
Winter Haven

Reply: We appreciate the opportunity to respond to the comments made by Dr. del Castillo.

In regard to statement #1 ("If the aspiration biopsy is negative for malignancy, it is worthless") it is our contention that thin needle aspiration is one of a number of techniques useful in reaching a diagnosis in breast lesions. A negative result via thin needle aspiration biopsy should be viewed in the context of results from all other diagnostic modalities applied. It should not be assumed, as Dr. del Castillo implies, that patients with negative cytology should be denied the benefit of other forms of breast diagnosis, e.g., mammography, open biopsy, follow-up physical examination, etc.

In regard to statement #2, we agree that one of the most important factors in the favorable outcome of breast carcinoma is early diagnosis. We have contacted Dr. Torsten Lowhagen, Co-Director of the Division of Cytology at the Radiumhemmet, Karolinska Hospital in Stockholm, Sweden, in regard to Dr. del Castillo's notion. . ."physicians in the Scandinavian countries, Sweden for example, do not do aspiration biopsies of the breast, but do open biopsies seven times more than we do in the United States." Dr. Lowhagen states in a personal communication dated January 2, 1986, "As for the comment by Dr. del Castillo regarding the fine needle aspiration diagnosis of breast lesions, in Sweden, I am surprised. I do not understand from which source he got his information. I feel that there is some confusion, and this should not be disseminated to the scientific world.

"During recent years, the fine needle aspiration almost has replaced the open biopsy in Karolinska Hospital. Although I do not have any definitive figure, I feel that fine needle aspiration of the breasts has reduced the open biopsy rate to nearly 10% of what it was 30 years ago."

Regarding statement #3, mentioning the slow growth of carcinoma of the breast, we agree that some lesions are surprisingly slow in their growth, but others, as is well known, behave in a more aggressive fashion. In either case, the earliest possible diagnosis obtained, using any or all of the available modalities, is the ideal.

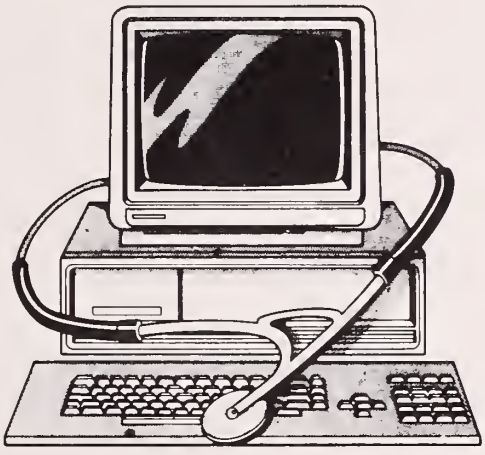
Having responded to these points, we again stress the desirability of fine needle aspiration biopsies in the diagnostic work-up of breast lesions. While this is especially so in the cases in which a positive cytologic diagnosis is rendered, negative or suspicious results when viewed properly within the context of other diagnostic information may provide useful data as well.

Jorge G. Arroyo, M.D., FIAC
Frank M. Taylor III, M.D., FIAC
Tampa

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345



All of our medical knowle



MIST—Medical Information Service via Telephone.

It allows any practitioner in the United States to consult quickly with specialists at the University of Alabama Medical Center at UAB. So it helps physicians help their patients more effectively and quickly—without increasing the cost! MIST operates all day, every day.

By simply dialing a single toll-free number, a physician has immediate access to the latest research, clinical findings and protocols. It's a sophisticated communications link between physicians and professionals in all areas of health care.

MIST relies on the internationally recognized research and patient care centers at the University of Alabama Medical Center at UAB. Specialists in all fields are available to provide specific medical information and to discuss patient-related



dge is sitting on your desk.

problems whenever they arise.

MIST isn't a new service.

Physicians and other health care professionals have relied on it as a fast source of medical information and advice for over 17 years.

MIST is a valuable link for rapid access to medical information. So the next time you need help with patient problems, referrals or emergency information, consult us.

Consult With A Specialist, Call

MIST:

1 800 292-6508
IN ALABAMA

1 800 452-9860
OUTSIDE ALABAMA

UAB The University of Alabama at Birmingham

FAIR OAKS HOSPITAL

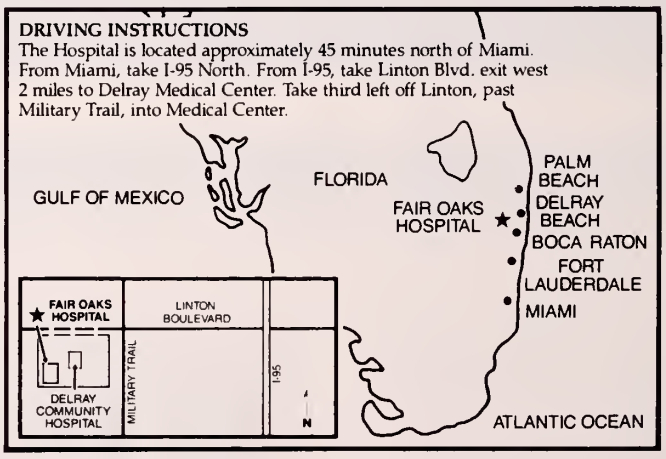
AT BOCA/DELRAY

Fair Oaks is a beautiful, new private psychiatric hospital offering state-of-the-art specialized treatment programs including:

- Yale-trained staff of full-time senior psychiatrists
- Comprehensive bio-medical patient evaluation to ensure individually tailored treatment
- Staff to patient ratio of 2.5 to 1
- Neuropsychiatric Evaluation Unit
- Depression evaluation and treatment
- Adolescent treatment program including a school program
- Addiction treatment program including medical detoxification from cocaine and opiates
- Florida affiliate of 800-COCAINE National Helpline
- Adult Treatment Unit
- Eating disorder program for treatment of anorexia, bulimia and severe obesity.

For more information, call or write:

Fair Oaks Hospital at Boca/Delray
5440 Linton Blvd.
Delray Beach, FL 33445
(305) 495-1000



Fair Oaks Hospital at Boca/Delray is managed by Psychiatric Institutes of America, which is a subsidiary of National Medical Enterprises.

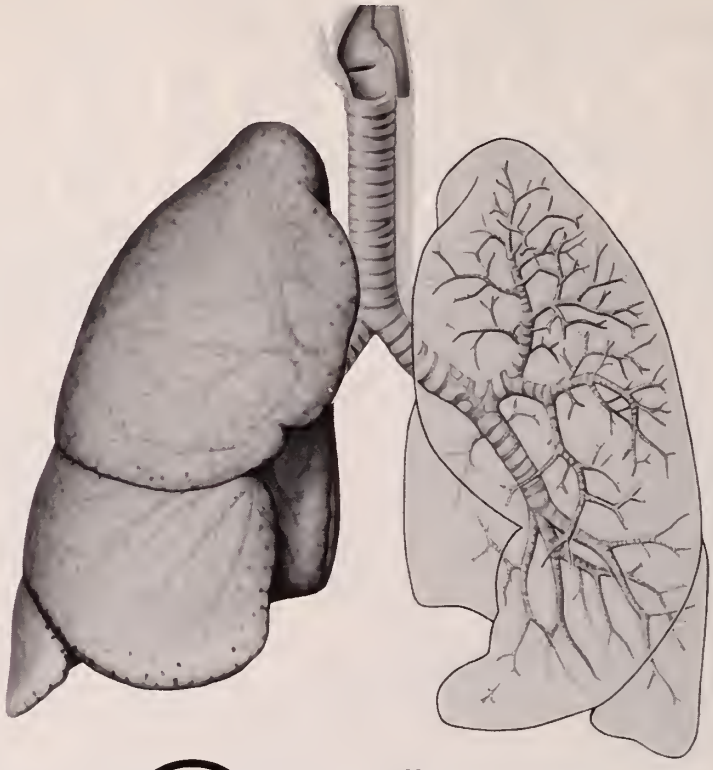
Coming soon from
Burroughs Wellcome Co. Research

WELLBUTRIN®
(Bupropion HCl)



Wellcome

Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

© 1984, ELI LILLY AND COMPANY

Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

400441

Motrin® 800 TABLETS mg

ibuprofen



Extra strength
Convenience
Economy

Upjohn 100 A Century of Caring 1886·1986

©1986 The Upjohn Company

J-6138 January 1986

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

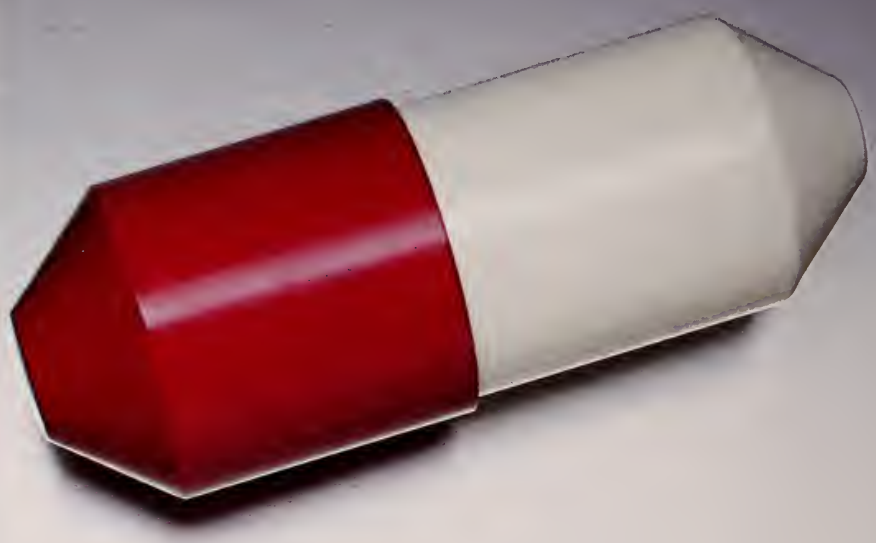
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L39

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



Potassium-Sparing DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 19 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.



a product of
SK&F CO.
Carolina, P.R. 00630

© SK&F Co., 1983

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
FEBRUARY 1986, Vol. 73, No. 2

Acquired Immunodeficiency Syndrome (AIDS) associated with blood transfusion: review of literature and report of two cases from Dominican Republic and Haiti

Arthur E. Pitchenik, M.D., Thomas J. Spira, M.D. and Eugene R. Schiff, M.D.

ABSTRACT: We describe two Caucasian women in whom the acquired immunodeficiency syndrome (AIDS) developed and whose only risk factor was the blood transfusions administered in Haiti and the Dominican Republic. In a review of the literature, we found reports of an additional non-Haitian patient and four Haitian patients who also may have contracted AIDS from blood transfusions administered in Haiti, and reports of a 3-9% seroprevalence of human T-cell leukemia virus III/lymphadenopathy associated virus (HTLV III/LAV) antibody among several Haitian populations. This data suggest the need to routinely screen blood donors in Haiti for evidence of HTLV III/LAV exposure as is currently being instituted for blood donors in the United States.

In light of the probable blood transfusion associated AIDS case in the Dominican Republic which borders Haiti, studies of the seroprevalence of HTLV III/LAV should be conducted to determine the need for monitoring blood donors in this country as well.

The Authors
ARTHUR E. PITCHENIK, M.D.
THOMAS J. SPIRA, M.D.
EUGENE R. SCHIFF, M.D.
Dr. Pitchenik is an Associate Professor of Medicine at the University of Miami School of Medicine in the Divisions of Pulmonary and General Medicine, Dr. Spira is Chief of the Clinical Immunology Laboratory at the Centers for Disease Control, Atlanta, Georgia, and Dr. Schiff is Professor of Medicine and Chief of the Division of Hepatology at the University of Miami School of Medicine.

As of January 6, 1986, there have been 263 blood transfusion related cases of the acquired immunodeficiency syndrome (AIDS) reported in the United States and 31 such cases reported from other countries.[1-7] With the discovery and isolation of human T-cell lymphotropic virus III/lymphadenopathy associated virus (HTLV III/LAV), the etiologic agent of AIDS, and recent development of methods to detect the presence of circulating antibody to this agent, blood donors in the United States are now routinely screened for evidence of exposure to this virus.[8-13] Screening of blood donors may also be useful in other countries where AIDS is prevalent.

We describe two women with AIDS whose only risk factor for acquiring the syndrome were blood transfusions administered in Port-au-Prince, Haiti, and Santo Domingo, Dominican Republic. This raises the issue of the need to screen blood donors in these two countries for evidence of HTLV III/LAV exposure.

Case reports ● Patient 1: A 55-year-old United States born white woman, a U.S. Navy employee stationed in Haiti since 1963, was in good health until 1978. At this time she was involved in an automobile accident and sustained multiple rib and bilateral lower extremity compound fractures requiring orthopedic surgery and multiple blood transfusions. The surgery was performed and blood transfusions administered in a hospital located in Port-au-Prince, Haiti. The blood donors could not be traced. In July 1980, she was treated for osteomyelitis of the right tibia and was subsequently transferred to Miami, Florida. She had no further health problems until February 1982 when she was admitted to the Miami Veterans Administration Medical Center because of fever, pain, tenderness, and swelling in her right leg following minor trauma. There was no history of ethanol or intravenous drug abuse. The patient was on no medications. On physical examination, she appeared

chronically ill. The temperature was 36.6C, blood pressure 130/70, pulse 102, and respiratory rate 22. There was diffuse abdominal tenderness and hepatomegaly. The right leg was warm, tender, and swollen below the knee. There were surgical scars over the right knee and hip and flexion contractures of both ankles. The remainder of the physical examination was within normal limits. Initial laboratory tests revealed hemoglobin 9.9 gm/dl and peripheral leukocyte count 4,000/mm3 with 3% lymphycytes. Hepatitis B surface antigen and antibody were negative. A specimen of arterial blood, drawn while the patient was breathing room air, revealed that the PaO2 was 75 mmHg, PaCO2 23 mmHg and pH 7.49. A chest radiograph revealed an infiltrate in the left upper lobe. Sputum, urine, and stool cultures grew Salmonella enteriditis. Fiberoptic bronchoscopy with transbronchial lung biopsy revealed Pneumocystis carinii pneumonia. Despite appropriate antibiotic therapy, the patient became progressively hypoxemic and disoriented and expired on the 30th hospital day. Autopsy revealed P. carinii pneumonia, disseminated cytomegalovirus infection and invasive esophageal and bladder candidiasis. There was no evidence of an underlying immunosuppressive disease.

Patient 2: A 55-year-old white Hispanic woman, a lifctime resident of the Dominican Republic, was in good health until December 1979 when a bleeding peptic ulcer developed which necessitated transfusion with three units of blood. Thc blood transfusions were administered in a hospital in Santo Domingo, Dominican Republic. The blood was donated by residents of Santo Domingo who could not be traced. One month later anorexia and malaise developed, also jaundice diagnosed as non-A, non-B hepatitis. Hepatitis B surface antigen and antibody to hepatitis B core antigen were negative; antibody to hepatitis B surface antigen was weakly positive. Liver biopsy obtained in May 1980 revealed mild chronic active hepatitis. She was treated with azathioprine in May 1980 for a period of 20 days and the drug was then discontinued. She had no further immunosuppressive medications. The patient continued to experience mild malaise but was otherwise well until July 1982 when Varicella zoster infection of the left eye and face developed. In August 1983 she was found to have candida pharyngitis and vaginitis and Herpes simplex stomatitis. After a three week history of weight loss, fever, and cough productive of whitish sputum, she was referred to Jackson Memorial Hospital, Miami.

On admission the temperature was 37.8C, blood pressure 130/90, and respiratory rate 16. She had thrush and occasional rales in both lung fields. The remainder of the physical examination was within normal limits. The hemoglobin was 10 gm/dl and peripheral leukocyte count was 6,900/mm3 with 12% lymphocytes. The SGOT was 63 U/ml, SGPT 65 U/ml, and total bilirubin .3 mg/dl. Subsequent testing for peripheral blood lymphocyte subpopulations revealed total T-cells (OKT-11) 37/mm3 (normal range 684-2,764), T-helper cells (OKT-4) 5/mm3 (normal range 395-1,727), T-suppressor cells (OKT-8) 18/mm3 (normal range 83-891) and OKT-4/OKT-8 .25 (normal range O.9-3.7). Hepatitis B surface antigen and antibody to hepatitis B core antigen were negative; antibody to hepatitis B surface antigen was weakly positive. A specimen of arterial blood drawn while the patient was breathing room air revealed that the PaO2 was 43 mmHg, PaCO2 34 mmHg and pH 7.41. A chest radiograph revealed bilateral diffuse interstitial infiltrates. Fiberoptic bronchoscopy with transbronchial lung biopsy revealed Pneumocystis carinii pneumonia. Smears and cultures of bronchial washings revealed no other organisms. Despite treatment with intravenous trimethoprim-sulfamethoxazole the patient died in respiratory failure. Autopsy revealed Pneumocystis carinii and cytomegalovirus pneumonia. There was no evidence of an underlying immunosuppressive disease.

The patient was in an upper socioeconomic class and frcquently traveled to the United States and other countries but had never visited Haiti. She underwent one session of acupuncture in Santo Domingo in 1981. She denied alcohol or intravenous drug abuse. The patient had sexual relations only with her husbancd, most recently in early 1982. Her husband appeared healthy and denied bisexuality or intravenous drug abuse. Although his peripheral blood lymphocytc and T-helper cell counts were normal, his peripheral blood T-suppressor cell count was elevated at 1,460/mm3.

Discussion • As of January 6, 1986, 15,909 adult patients and 229 pediatric patients meeting CDC surveillance definitions for AIDS[14,15] had been reported to CDC from physicians and health departments in the United States.[1] Of these 252 (2%) of the adult patients and 34 (15%) of the pediatric patients (all less than five years of age) had been tranfused with blood or blood components within five years of illness onset and had no other known risk factor for AIDS. Among those transfusion associated AIDS cases reported in more detail,[1,16-22] the majority of patients received transfusion in New York, California, New Jersey, or Florida, the four states with the largest number of reported cases of AIDS. Transfusions consisted of various combinations of packed red blood cells, fresh frozen plasma, whole blood and/or platelets with no single type of blood component being administered to all patients. The time between transfusion and onset of illness ranged from four to 62 months (median 29 months for adults and 14 months for children) and the number of units received ranged from two to 48. Two patients received only two units of packed red blood cells with only one unit coming from a high risk donor suggesting that exposure to only one unit may result in transmission.[16] One patient with transfusion associated AIDS had serologic and virologic evidence of HTLV III/LAV infection but was seronegative for antibodies to HTLV I, HTLV II, cytomegalovirus, Epstein-Barr virus and hepatitis B virus. This suggests that HTLV III/LAV may be the sole viral agent causing AIDS via blood transfusion.[22] Among those reported transfusion associated AIDS cases where investigation of donors was conducted, there was always at least one donor from a high risk goup and/or a donor with generalized lymphadenopathy, abnormally low ratio of peripheral blood T-helper/T-suppressor lymphocytes, circulating antibodies to HTLV III/LAV or HTLV III/LAV isolated from peripheral blood lymphocytes.[10,16,21-23] HTLV III/LAV was isolated from 22 (84%) of 25 persons at high risk for AIDS who had donated blood to patients who later contracted transfusion associated AIDS. The HTLV III/LAV was isolated between 12 and 52 months (mean 28 months) after they had donated blood. Antibodies to HTLV III/LAV were detectable by the ELISA assay

in serum samples obtained from each person at the time the virus was isolated.[23] Except for possible generalized lymphadenopathy in some, all donors were asymptomatic when they donated blood. A few, however, subsequently contracted AIDS. This further demonstrates that persons infected with HTLV III/LAV may be asymptomatic yet persistently or intermittently viremic for years and supports the use of serologic screening of donated blood for the prevention of transfusion related AIDS.

In addition to the transfusion related AIDS cases reported from the United States, there have been a total of 25 non-Haitian patients with transfusion related AIDS from five countries in Europe.[2-4] Of these patients, one had received transfusions in Haiti and Martinique (HTLV antigens were shown to be expressed on this patient's blood cells). In addition, there was one transfusion associated AIDS case reported from Israel,[5] four pediatric transfusion associated AIDS cases reported from Australia[6] and one possible pediatric case from Canada.[7] It is likely that more transfusion related AIDS cases have occurred outside the United States where reporting of AIDS may be less complete.

Both of our patients probably had AIDS related to their blood transfusions since there were no other known risk factors for the syndrome. The long time interval between the blood transfusions and the diagnosis of AIDS (four years in both patients) is within the time range of other reported transfusion related cases.[16] Patient 1 was a U.S. born Caucasian woman who had multiple blood transfusions in Haiti. That five Haitian patients (two women and three men) residing in Haiti were also reported to have contracted AIDS from one and a half to six years following blood transfusions[24] further supports that blood transfusion related AIDS may be an emerging problem in Haiti. Only one of these patients had an additional risk factor, homosexuality, which could account for his contracting AIDS. Patient 2 had an acupuncture performed in Santo Domingo. Conceivably this could have been a route of transmission of AIDS but there have been no reported cases related to this procedure. Further she contracted at least one other viral infection (non-A, non-B hepatitis) from the transfused blood. We also can not exclude that patient #2, may have become infected through heterosexual contact with her husband (who had an immune defect in his peripheral blood; i.e. increased T-suppressor cell count). However, the patient's husband was assymptomatic and had no known risk factors for AIDS except for sexual contact with his wife. Although she represents the first reported case of AIDS in a resident of the Dominican Republic and the first reported case following transfusion from blood collected in that country, there has been a case of AIDS in a Dominican (reported from the United Kingdom)[4] and two cases in infants born to Dominican mothers who were residing in the United States.[25]

In a recent survey conducted in the Dominican Republic, 300 blood specimens were collected from individuals coming to a venereal disease clinic, a drug abuse center, and in homosexual male prostitutes. The prevalence of HTLV III/LAV antibody was found to be 1% in the veneral disease clinic and drug abuse center patients and close to 10% in the homosexual prostitutes. In this same study, four (9%) of 45 Haitian migrants working in the Dominican Republic were found to have HTLV III/LAV antibody.[26] In a serologic survey conducted in 1983 in French Guiana among Haitians who had immigrated there over the previous ten years,[27] 15 (eight women and seven men) of 211 Haitian immigrants (7.1%) were positive for HTLV III/LAV antibodies as measured by an ELISA test.[28] Six of the 15 specimens were also positive by the Western Blot Test.[29] In another serologic survey of 96 middle to upper income Haitians residing in Haiti, the prevalence of antibodies to HTLV III/LAV was 3%.[30]

Since screening of blood donors for HTLV III/LAV antibody is now done routinely in the United States, the current data would support similar screening of donors in Haiti. In light of the probable blood transfusion associated AIDS case in the Dominican Republic and the 10% seroprevalence of HTLV III/LAV reported among homosexual prostitutes residing in the Dominican Republic, further studies of the seroprevalence of HTLV III/LAV should be conducted to determine the need for monitoring blood donors in this country as well.

Acknowledgment

The authors thank AIDS activity, Division of Virology, Centers for Infectious Diseases, CDC, for data on transfusion related cases in the United States, Dr. Peter Drotman for reviewing this paper, and Suzanne Smith for assistance in preparing it.

References

1. CDC: Update: Acquired Immunodeficiency Syndrome (AIDS) — United States, MMWR 34:245-248, 1985.
2. Andreani, T.; LeCharpentier, Y.; Brouet, J.C., et al: Acquired Immunodeficiency with Intestinal Cryptosporidiosis: Possible Transmission by Haitian Whole Blood, Lancet 1(8335):1187-1191, 1983.
3. CDC: Update: Acquired Immunodeficiency Syndrome — Europe, MMWR 34:583-589, 1985.
4. CDC Update: Acquired Immunodeficiency Syndrome — Europe, MMWR, 33:607-609, 1984
5. Delpre, G.; Ilfeld, D.; Pitlik, S., et al: AIDS after Coronary Bypass Surgery, Lancet 1(8368):103, 1984
6. O'Duffy, J.F. and Isles, A.F · Transfusion Induced AIDS in Four Premature Babies, Lancet 2(8415):1346, 1984
7. CDC: Acquired Immunodeficiency Syndrome (AIDS) — Canada, MMWR 32:635-636, 1983.
8. Gallo, R.C.; Sarin, P.S ; Gelmann, E.P., et al: Isolation of Human T-cell Leukemia Virus in Acquired Immune Deficiency Syndrome (AIDS), Science, 220:865, 1983.
9. Barre-Sinoussi, F.; Chermann, J C.; Rey, F., et al: Isolation of T-lymphotropic Retrovirus from Patient at Risk for Acquired Immune Deficiency Syndrome (AIDS), Science 220:868-871, 1983.
10. Jaffe, H.W ; Francis, D.P.; Mclane, M.F., et al: Transfusion Associated AIDS: Serologic Evidence of Human T-cell Leukemia Virus Infection of Donors, Science 223:1309-1312, 1984.

11 Weiss, S.H.; Goedert, J.J.; Sarngadharan, M.G.; Bodner, A.J.; Gallo, R.C., and Blattner, W.A.: Screening Tests for HTLV III (AIDS Agent) Antibodies, JAMA 253:221-225, 1985.
12. Quinn, T.C.: Perspectives on Future of AIDS, JAMA 253:247-249, 1985.
13. CDC: Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to Virus Causing Acquired Immunodeficiency Syndrome, MMWR 34:1-5, 1985.
14 CDC: Update on Acquired Immune Deficiency Syndrome (AIDS) — United States, MMWR 31:S07-S08, S13-S14, 1982.
15. Thomas, P.A.; Jaffe, H.W.; Spira, T.J.; Reiss, R.; Guerrero, I.C., and Auerbach, D.: Unexplained Immunodeficiency in Children. Surveillance Report, JAMA 252:639-644, 1984
16. Curran, J.W.; Lawrence, D.N.; Jaffe, H., et al: Acquired Immunodeficiency Syndrome (AIDS) Associated with Transfusions, N. England J. M. 310:69-7S, 1984.
17. CDC: Possible Transfusion-Associated Acquired Immune Deficiency Syndrome-California, MMWR 31:6S2-6S4, 1982.
18. Amman, A.J.; Cowan, M.J., Wara, D.W., et al: Acquired Immunodeficiency in Infant: Possible Transmission by Means of Blood Products, Lancet 1:956-958, 1983.
19. Jett, J.R.; Kuritsky, J.N.; Katzmann, J.A., and Homburger, H.A.: Acquired Immunodeficiency Syndrome Assoicated with Blood Product Transfusions, Ann. Int. Med. 99:621-624, 1983.
20. Deresinski, S.C.; Cooney, D.P.; Auerhach, D.M.; Amman, A.J.; Luft, B., and Goldman, H.: AIDS Transmission via Transfusion Therapy, Lancet 1(8368):102, 1984
21 Feorino, P.M.; Kalyanaraman, V.S.; Haverkos, H.W., et al: Lymphadenopathy Associated Virus Infection of Blood Donor-Recipient Pair with Acquired Immunodeficiency Syndrome, Science 225:69-72, 1984.
22. Groopman, J.E.; Salahuddin, S.Z., and Sarngadharan, M.G.: Virologic Studies in Case of Transfusion-Associated AIDS, N. England J. M. 311:1419-1422, 1984.
23. Feorino, P.M.; Jaffe, H.W.; Palmer, E., et al: Transfusion Associated Acquired Immunodeficiency Syndrome. Evidence for Persistent Infection in Blood Donors, N. England J. M. 312:1293-1296, 1985.
24. Pape, J.W.; Liautaud, B.; Franck, T., et al: Characteristics of Acquired Immunodeficiency Syndrome (AIDS) in Haiti, N. England J. M. 309:945-9S0, 1983.
25. Oleske, J.M.; Minnefor, A.B.; Cooper, R., et al: Immune Deficiency Syndrome in Children, JAMA 249(17):234S-2349, 1983.
26. Koenig, R.E.; Pittaluga, J.; Bogart, M.; Castro, M., and Levy, J.A.: Detection of antibodies to AIDS-Associated Retroviruses (ARV) in Dominican Republic (abst.), CDC Sponsored International Conference on Acquired Immunodeficiency Syndrome, Atlanta, Georgia, April 17, 1985; Session 22, p. 67.
27. Gazzolo, L.; Gessain, A.; Robin, Y.; Rober-Guroff, M., and De-The, G.: Antibodies to HTLV III in Haitian Immigrants in French Guiana, N. England J. M. 311:1252-12S3, 1984.
28. Saxinger, W.C. and Gallo, R.C.: Application of Indirect Enzyme-Linked Immunosorbent Assay Microtest to Detection and Surveillance of Human T-cell Leukemia-Lymphoma Virus, Lab. Invest. 49:371-377, 1983.
29. Towbin, H.; Stachlin, T., and Gordon, J.: Electrophoretic Transfer of Proteins from Polyactilamide Gels to Nitrocellulose Sheets: Procedure and Some Applications, Proc. Nat. Acad. Sci. USA 76:43S0-43S3, 1979
30. Pitchenik, A.E.; Spira, T.J., Elie, R., et al: Prevalence of HTLV III/LAV Antibodies Among Haitians, N. England J. M. 312:705, 1985.

● Dr. Pitchenik, VA Medical Center (Medical Service 111), 1201 N.W. 16th Street, Miami 33125.

Cardiac transplantation

C. Richard Conti, M.D., Daniel R. Salomon, M.D., and Michael J. Carmichael, M.D.

ABSTRACT: The number of heart transplants being performed in the United States has increased markedly in the last few years. The ideal transplant patient is young, healthy except for a failing heart, understands the complexity of the medical therapy required, is emotionally stable, and has no obvious contraindication to transplantation. Contraindications include active infection and organ failure such as renal disease or stroke and alcohol or drug abuse. Medical cost of the procedure is not trivial and someone must assume financial responsibility. Following transplantation, numerous cardiac biopsies are required and the patient is committed to a lifetime treatment with cyclosporine and varying doses of steroids.

The Authors
C. RICHARD CONTI, M.D.
DANIEL R. SALOMON, M.D.
MICHAEL J. CARMICHAEL, M.D.

Dr. Conti is Professor of Medicine, Chief of Cardiology, Dr. Salomon is Assistant Professor of Medicine, Medical Director Renal Tranpslant Program, Transplant Immunologist, Cardiac Transplant Program, and Dr. Carmichael is Assistant Professor of Surgery, Director, Cardiac Transplant Program, University of Florida College of Medicine, Gainesville.

The number of cardiac transplantations in the United States has increased considerably in the last five years. Expected survival at one to two years is approximately 80%. Most survivors are able to return home to a relatively normal family and occupation life; however, all patients require close medical surveillance for the rest of their lives. Both medical and psychosocial selection criteria are stringent in order to optimize the chance of long-term survival.

Medical criteria for selection of cardiac transplant candidates • A. Indications:

1. Patients should be in functional class III or IV and have a poor six-month prognosis for survival.

2. Patients should be less than 50 years of age. These patients have a better survival record than those greater than 50 years of age. Transplantation can be done in children and infants but donor availability is a major problem. Experience with this group is limited. Occasionally patients older than age 50 are considered. These are patients who are physically young and have no other problems related to aging.

3. Patients must be healthy other than having end-stage cardiac disease. This means patients cannot have severe diabetes mellitus, renal disease, malignancy, chronic infections or significant peripheral vascular disease. More recently, relatively healthy patients with adult onset, insulin independent diabetes mellitus have been considered acceptable candidates.

4. Heart transplantation patients (and families) must accept full responsibility for medical compliance as they will be required to follow a complex medical regimen for the rest of their lives.

5. Patients must be emotionally stable with realistic attitudes demonstrated to past and current illnesses. In this regard, all patients are evaluated by a clinical psychologist, social worker, and a member of the clergy prior to transplantation.

Contraindications to cardiac transplantation • 1. Systemic disease such as severe peripheral vascular disease or insulin requiring diabetes mellitus.

2. Active infection.

3. Pneumonia, recent or unresolved pulmonary infarction, or any undiagnosed infiltrate on chest x-ray.

4. Severe pulmonary hypertension with a fixed pulmonary vascular resistance of over six to eight Wood units (these patients may be candidates for heterotopic heart or lung transplantation).

5. Moderate to severe azotemia and/or hepatic abnormalities. In some instances these abnormalities may be related to right heart failure. If they are mild to moderate in severity, these patients may be acceptable since these changes are reversible once cardiac function is normal.

6. Given high dose steriods, surgical stress, and immunosuppression, the acute complications of peptic ulcer disease could be potentially devastating.

7. Any central nervous system disorder is a major contraindication, ie, seizure disorder, previous stroke, transient ischemic attacks.

8. Obesity. This is not an absolute contraindication but suggests that compliance with a strict medical regimen may be a problem. In addition, obese patients have more problems with hypertension and diabetes mellitus than nonobese patients.

9. Alcohol or drug abuse and/or mental illness is a major contraindication since compliance is required of all heart transplantation patients.

Medical care costs • The patient's relatives, friends or insurance agencies must be responsible for medical care costs. Any combination is acceptable. Costs vary throughout the United States but a reasonable minimal estimate for hospitalization is in the neighborhood of $60,000. There are many institutions in which the initial deposit required is as much $125,000.

It should be emphasized, however, that availability of financial resources does not guarantee acceptance into any transplant program. Patients still must satisfy the rigid entry criteria for any program which have been outlined previously.

The range of medical care costs can also vary widely. Pre-transplant evaluation will vary from $2,500 to $5,000. If the patient is stable and lives close to the transplant institution, then costs can be minimized; however, if the patient is required to live away from home near the transplant institution then obviously food and lodging must be paid for while awaiting an appropriate donor as an outpatient. In contrast, if a patient is severely ill and requires intensive care treatment during the waiting period, costs can rapidly escalate to $100,000 or more. Therefore, inpatient transplantation costs may vary from $40,000 to over $100,000 depending on the individual patients response to therapy.

Outpatient costs in the immediate postransplantation period can vary but approximately $5,000 can be expected for the first year. This takes into consideration the fact that the patient has to live near the institution of the cardiac transplantation team in order to return for frequent care and cardiac biopsies.

Medical therapy following successful cardiac transplantation • Given a successful surgical result and an uncomplicated recovery immediately following transplantation, immunosuppressive therapy is the key to continued success. This is accomplished with prednisone and the new immunosuppressive agent, cyclosporine.

Experience has shown that it is almost impossible to detect rejection in the cardiac transplant unless routine endomyocardial cardiac biopsies are performed. Most protocols require that a cardiac biopsy be performed weekly for several weeks following surgery. By the end of the first month the schedule gradually changes to every other week, then monthly, etc. After 12 months the endomyocardial biopsies can be performed twice yearly. Rejection of the transplanted heart is evidenced on the biopsy by the interstitial infiltration of activated lymphocytes and by damage to the myocardial muscle bundles. Transplantation rejection may occur at any time but is most common in the first four months and affects at least half the patients. Rejection is treated with high dose, intravenous steroid therapy. Alternatively, special antibody preparations, i.e., antilymphocyte globulin, which eliminate the activated lymphocytes in the heart tissue can be used. The application of highly specific monoclonal antibodies to treat or prevent rejection promises to be an exciting area in the near future.

Cyclosporine is administered orally at an initial dose of 10 mg/kg/day as two divided doses. Clinical experience with cyclosporine is essential because there is great individual variability in response to the drug; thus levels must be monitored from the earliest time postoperatively. This requires the ready availability of a laboratory with a reliable assay. Trough cyclosporine levels should not exceed 400-500 ng/ml whole blood (150-300 ng/ml plasma). Renal toxicity is a common and sometimes serious result of elevated cyclosporine levels.

The patient's susceptibility to opportunistic infection is also increased unnecessarily by prolonged elevations of cyclosporine blood levels or high doses

of steroids. Opportunistic infections with cytomegalovirus (CMV), Pneumocystis carinii, Aspergillus, Nocardia, Herpes virus and Ebstein-Barr virus may have a disastrous effect on the patient and the transplant. Therefore, the cardiac transplantation team must carefully and appropriately adjust both the cyclosporine and the prednisone dosages avoiding too little immunosuppression and rejection or too much immunosuppression and toxicity.

- Dr. Conti, Chief, Division of Cardiology, University of Florida College of Medicine, Box J-277, JHMHC, Gainesville 32610.

Thymoma associated with Lupus syndrome and associated findings of pulmonary sequestration

Gabriel Mayer, M.D., F.A.A.F.P., Meredith Scott, M.D., F.A.C.C.P., and Michael Nocero, M.D., F.A.C.C.

ABSTRACT: A 17-year-old white female presented to the hospital with right-sided chest pain and respiratory distress. Chest x-ray and CT scanning confirmed the presence of a large cystic mass compressing the right lower mainstem bronchus with atelectasis and bronchopneumonia present. At surgery the patient had a large cystic thymoma and also an accessory lung lobe which was an extralobular pulmonary sequestration. Significant laboratory findings included highly positive ANA and anti-DNA titers making a diagnosis of systemic lupus erythematosus. The syndrome of thymoma and lupus is rare but has been described previously. The association of extralobular pulmonary sequestration may be coincidental; however, this is the first simultaneous description in the literature.

The Authors
GABRIEL MAYER, M.D., F.A.A.F.P.
MEREDITH SCOTT, M.D., F.A.C.C.P.
MICHAEL NOCERO, M.D., F.A.C.C.

Dr. Mayer is in the Department of Family Practice, Dr. Scott is in the Department of Cardiothoracic Surgery, and Dr. Nocero is in the Department of Cardiology at Florida Heart Institute, Florida Hospital Medical Center.

About 10% of all primary mediastinal neoplasms are thymomas and their occurrence is rather evenly divided in both sexes and provide a variety of age groups although more rare in children and younger adults. Less than 25% exhibit true malignant degeneration and prognosis is usually related to their invasive nature rather than histopathologic findings. Three cellular types are identified: lymphocytic, predominantly epithelial, and mixed lymphocytic-epithelial. Many associated clinical syndromes have been described. With thymomas the most frequently occurring is myasthenia gravis and there are less frequent immunologic diseases.[1-4]

Pulmonary sequestration is believed to be a congenital malformation whereby an anomalous arterial supply aids in formation of this tissue. Both extralobar and intralobar sequestration are described although the former is far more rare and is associated with other congenital abnormalities. The extralobar form is thought to originate due to persistent communication between primitive gut tissue and the primary lung bud tissue during embryonic involvement. Frequently other foregut malformations are associated with this form.[5]

Case report • A 17-year-old white female in previously good health presented with right-sided chest pain, shortness of breath, fever and cough. Significant admission laboratory data included a leukocytosis of 14,000 with a left shift and a PO_2 of 55 mmHg on room air. X-ray revealed a right chest mass with atelectasis and compression of the right lower main stem bronchus and secondary bronchopneumonia. A CT scan on admission confirmed the finding of this large mass and described it as a large cystic mass arising from the mediastinum and contiguous with the right heart border and compressing upon the right lower lobe of the lung and the right lower bronchus. An echocardiogram showed the

mass to be adjacent to the right heart border but not involving the epicardioum.

Surgical findings. On the third day the patient was taken to the operating room and a right lateral thoracotomy was performed which disclosed a large cystic mass resting on the mainstem bronchus and pericardium extending up into and evidently arising from the anterior mediastinum. The mass was not invading adjacent structures and was dissected free. It was sent to pathology along with two smaller mediastinal masses. It was also noted that an infarcted hemorrhagic mass was present in the middle lobe but separate from it. It appeared to be a sequestration that had infarcted and was necrotic; therefore, it was excised and sent to pathology for examination.

Pathologic findings. The cystic mass measured 7.5 cm at its greatest diameter and was enclosed by a fibrous capsule of variable thickness with smooth external surface without any breaks through the capsule. On frozen section this was diagnosed as a lymphocytic thymoma. Another mass measured 4.5 cm at its greatest diameter and was also covered by a smooth glistening capsular layer suggestive of pleural tissue. It contained multiple fibers septa with parts being necrotic suggestive of pulmonary sequestration.

Histologic examination of the cystic mass disclosed it to be a lymphocytic thymoma with mixed lymphocytic and epithelial components. It contained areas of normal thymic tissue with Hassall's corpuscles as well as other areas with nonmitotic proliferation and portions designated as having medullary differentiation. Examination of the smaller mass disclosed it to be lung parenchyma with characteristics suggestive of extralobular pulmonary sequestration. It was covered by its own pleura and had a blood supply that appeared to come from the systemic circulation with absent pulmonary arteries. In this case the arterial supply seemed to originate from one of the bronchial arteries.



Fig. 1. — Plain chest x-ray demonstrates large right-sided chest mass and right lower lung atelectasis.

Significant laboratory and immunologic data. On admission the patient had a sedimentation rate (westergreen) of 54. An RA latex was negative and an ANA was positive with a 1:80 titer speckled pattern and 1:320 titer peripheral pattern. Her anit-DNA (double stranded) was also positive. These tests were repeated two weeks later and at that point the ANA titer was 1:640 speckled pattern and anti-DNA was still positive. Antigen typing results were HLA: A11, B51, B8, CW3. Dr: DR4.

T cell and B cell subsets were analyzed and a total white blood cell count at that time was 13,100 and total lymphocyte count 4,716 (N = 1200 to 3000/cu mm). Lymphocyte markers reacted with monoclonal antibodies and were as follows: T11 (total T lymphocytes): 59% (N = 50 to 80%); total 2937/cu mm (N = 1050 to 1680/cu mm); t4 (helper/inducer subset): 35% (N = 33 to 53%); total T4: 1742/cu mm (N = 693 to 1113/cu mm); T8 (suppressor/cytotoxic subset): 23% (N = 11 to 30%); total T8 1145/cu mm (N = 231 to 630/cu mm); T4 to T8 ratio: 1.5 (N = 1.1 to 3.5); B1 (total B lymphocytes): 5% (N = 5 to 21%); total B1 249/cu mm (N = 105 to 441/cu mm). The interpretation discloses an elevated T cell but normal ratio of T cell subsets as well as a slightly elevated B cell count. Further studies included antithyroid globulin antibody and antithyroid microsomal antibody which were both negative.

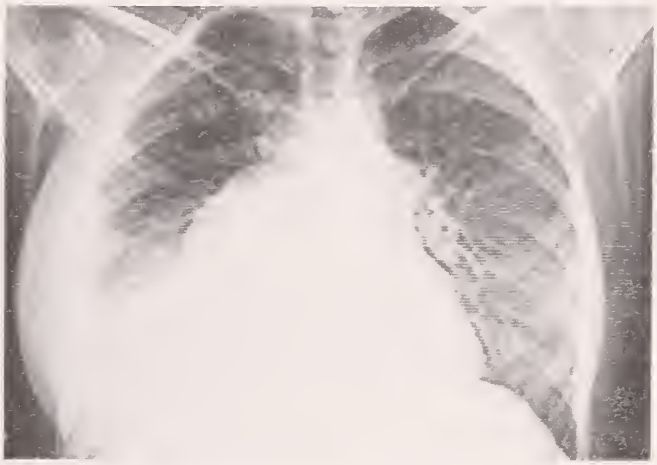


Fig. 2. — Frontal view CT scan collaborates findings in plain chest film.



Fig. 3. — CT scan horizontal view of the thorax demonstrates large chest mass in the right anterior thorax contiguous with the right heart border and compressing the right lower bronchus and extending toward the mediastinum. The mass seems to be encapsulated with cystic elements within.

Immunoglobulin levels were as follows: IgG — 1130 (N = 639 to 1349), IgA — 223 (N = 70 to 312) and IgM — 223 (N = 56 to 312). The total IgE was slightly elevated at 251 (N = 10 to 150).

Twelve weeks postoperative the patient's incisions were healed and her chest x-ray was within normal limits; however, fatigue and migratory polyarthritis developed and the anti-ANA pattern was 1:680 speckled and the anti-DNA was positive.

Discussion • Thymomas are classified according to cellular type as lymphocytic, predominately epithelial, and mixed lymphocytic-epithelial. In several large review studies there has been no statistically significant difference in the predominant cell type, nor did cell type influence the likelihood of mitotic differentiation. Historically the most significant factors affecting the prognosis in thymomas have been invasion of adjacent structures and apparently this occurs just as often with well differentiated thymomas of all three types.[2]

Thymomas with local invasion of structures and extracapsular infiltration of bronchi, for example, or pleural wall have characteristically a poor prognosis and recur frequently despite aggressive surgical therapy. Radiotherapy has been used with some success but overall five year survival rates have been less than 50% in several cases. In a large series at Johns Hopkins University, 65 patients with thymomas were studied and out of 37 patients with noninvasive thymomas there was a 0% recurrence or death rate. However, with invasive thymomas, three out of 17 patients were alive after five years.[1,4]

Of more significant interest and prognostic correlation has been the occurrence of associated symptoms. The thymus is a primitive B and T cell precursor gland and many syndromes associated with thymic proliferation have been described. The most commonly described has been myasthenia gravis and/or myasthenial-like syndrome and in most studies this has affected nearly 50% of patients.[6] Other frequently associated clinical syndromes with thymomas have been red cell aplasia and hypogammaglobulinemia.[7,8] There have also been associations with thyroid carcinoma and also with antithyroid microsomal antibody presence.[9] Less readily described have been lupus-like syndromes, arthritis and chronic T-cell lymphocytic leukemia. Also an increased incidence of B8 and DR4 histocompatibility antigens have been reported in cases of lupus.[1,4,10]



Fig. 4. — This depicts the cystic thymoma measuring 7.5 cm at its greatest diameter.

Pulmonary sequestration is also a rather rare clinical syndrome with intrapulmonary being much more frequent than extrapulmonary. It is believed that extrapulmonary sequestration results from a congenital malformation during primitive foregut development in the embryo and associated clinical abnormalities have been described in the literature.[5] Although thymic cysts have been occasionally described as a congenital abnormality resulting from a retained thymus tissue from the fourth pharangeal cleft as the thymus descends into the chest wall, the relationship between thymoma and extrapulmonary sequestration cannot be established. Thymoma and the associated clinical syndromes described have an obvious autoimmune relationship.[1,6] Systemic lupus erythematosis was established primarily by laboratory means although the patient had some early clinical symptomatology. The simultanous occurrence of extrapulmonary sequestration may be coincidental although it is highly against the odds that these two clinical entities should occur in the same patient.

References

1. Salyer, W R , and Eggleston, J C Thymoma Clinical and Pathological Study of 65 Cases, Cancer 37:229-249, 1976
2. Grav, G F , and Gutowski, W T Thymoma: Clinicopathologic Study of 54 Cases, Am J Surg. Path. 3:235-249, 1979.
3. Barata, M A.; Martini, N ; Huvos, A ; Aguilar, R I , and Beattie, E J., Jr Thymoma: Clinicopathologic Features, Therapy and Prognosis, Cancer 34:389-396, 1974
4. Bernatz, P E , Khonsari, S , Harrison, E G , and Taylor, W F Thymoma Factors Influencing Prognosis, Surg Clinics N A 53:885-892, 1973.
5. Sabiston, D C., and Spencer, F.C : Surgery of Chest, 4th ed, Philadelphia, W B Saunders Company, 1983; pp 685-688
6. Olanow, C W , and Wechsler, A S. Surgical Management in Myasthenia Gravis In: Sabiston, D C., and Spencer, F.C , eds. Surgery of Chest. 4th ed, Philadelphia, W B Saunders Company, 1983; pp 849-869
7. Socinski, M A , Ersbler, W B ; Frankel, J P , Albertini, R J.; Ciongoli, A K , and Krawitt, E.L., et al: Pure RBC Aplasia and Myasthenia Gravis, Arch Intern Med 143:543-546, 1983
8. Degos, L , Faille, A , Housset, M , Boumsell, L., Rabian, C., and Parames, T Syndrome of Neutrophil Agranulocytosis, Hypogammaglobulinemia, and Thymoma, Blood 60:968-972, 1982
9. Donaldson, J O ; Grunnet, M L , and Thompson, H G. Concurrence of Myasthenia Gravis, Thymoma, and Thyroid Carcinoma, Arch. Neurol 40:122-124, 1983
10. Thomas, J.; DeWolf-Peeters, C.; Tricot, G.; Bekaert, J., and Broeckaert-Van Orshoven, A : T-cell Chronic Lymphocytic Leukemia in Patient with Invasive Thymoma in Remission with Chemotherapy, Cancer 52:313-317, 1983.

• Dr. Mayer, Florida Heart Institute, Florida Hospital Orlando, 601 E. Rollins, Orlando 32803.

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC. P.O. BOX 2411, JACKSONVILLE, FL 32203 TELEPHONE 904/356-1571

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

A new team of arthritis specialists teams up.

Announcing Florida's Only Arthritis Treatment Center.

A complete team of multidisciplinary specialists, from physicians, nurses, occupational and physical therapists, to social workers, psychologists, pharmacists and nutritionists, will help your patients learn how to cope with their arthritis, lupus, scleroderma or other rheumatic disorders.

Together the team custom designs an individualized program for each patient. Their intensive inpatient program teaches patients how to exercise, avoid joint damage, and cope with the demands of daily living.

Other important members of the treatment team are the patients, their families and their personal physicians. We agree with other successful arthritis treatment centers across the country: teamwork brings results.



Our multidisciplinary treatment program, covers a wide range of activities. From nutritional and pharmaceutical counseling to physical and occupational therapy.

The Parkway Center for Arthritis and Rheumatic Diseases

"New Hope for Independent Living"

AMI Parkway Regional Medical Center

Thriving on Achievement

160 N.W. 170th Street,
North Miami Beach, FL (305) 651-1100

SPECIAL ARTICLE

Changing the rules

Richard J. Feinstein, M.D.

For the nondermatologist reading this story, I want to refresh your memory about seborrheic keratoses. They are dark gray or brown warty lesions that grow on the skin of older people. Some physicians believe that they are genetically determined and most have ascertained that they are apparently not related to sun exposure. Some patients have hundreds of them on the face, trunk, and extremities and while some may itch or, in theory at least, affect the function of such places as the eyelids, most produce no symptoms except for their effect on the psyche and libido. For most elderly people, these brown "moles" are age and ugliness incarnate, and their removal is extremely important for self-confidence and a happy life.

While some physicians may excise and suture the skin around these lesions, dermatologists frequently remove keratoses by scraping them off with a currette or freezing them with liquid nitrogen. Please do not interpret this as bragging, but I have removed as many as 200 seborrheic keratoses from a single patient in less than 15 minutes. The keratoses sit right on the skin surface and are extremely easy to remove, often without anesthetic.

Most people who have seborrheic keratoses are elderly, and almost all of them are insured by Medicare. Dermatologists, whether they accept assignment or not, submit charges to Medicare for their removal and we have never received any directive from the Health Care Financing Administration (HCFA) that these were not to be removed or billed to Medicare, nor were we ever given a limit as to how many could be removed at any one session or during any one year.

When I am asked about these lesions, I inform my patients that they are completely benign, will never become malignant, and will most likely never go away on their own. I also inform my patients of the relative ease of removing them and of their freedom of choice to have them excised or left alone. Some patients decide for and others against such surgical intervention, banal as the surgery may seem, based upon individual preferences, fears, and desires for more perfect skin. I am convinced that almost all the other dermatologists in Florida treat their patients and these benign lesions in an almost identical way. Since Medicare has expressed no formal regrets about paying in part for their removal, many of these lesions, I am sure, are removed at government expense each year.

As the Secretary-Treasurer of the Florida Society of Dermatology, I received a call from one of our members several months ago who related that Medicare had performed an audit of his charts because they believed that he was removing too many seborrheic keratoses. After the audit was completed, they asked him to repay $35,000 for overutilization. He asked for a hearing by the Florida Medical Foundation, at which no other dermatologists were to be invited to attend, leaving the final decision about his audit and overutilization to physicians who are not familiar with dermatology or with the procedures generally used to remove these growths. A dermatologist was ultimately invited and did appear.

The Author
RICHARD J. FEINSTEIN, M.D.
Dr. Feinstein is an Associate Clinical Professor in the Department of Dermatology, University of Miami School of Medicine and a Contributing Editor of The Journal.

Though I profess to know little about the details of his case, since I have not reviewed his medical records nor attended the audit, I am worried about the principles involved here. Medicare seems to be changing the rules that govern the activity of physician providers without adequate notification, and they are accusing physicians of overutilizing procedures for which no limits were ever set.

I could possibly though regrettably begin to understand it if HCFA initiated new rules which prospectively prohibit the removal of all seborrheic keratoses in the future, or limit future removal to ten per visit or twenty per year, or limit the total amount of dollars spent on their removal each calendar year, but it just is not fair to retrospectively deny payment for a procedure when no notice was ever given about it beforehand.

Most dermatologists charge $20 or $30 per lesion, and then drastically reduce the cost of subsequent lesions removed at one visit. The patient from whom I removed 200 lesions at one visit, for example, was charged $200.00, or about a dollar each. I can presume that the $35,000 requested by Medicare of this dermatologist represents hundreds of patients and literally thousands of lesions.

In England, committees of physicians and lay representatives still function to determine who shall get renal dialysis, and who shall die for the lack of it.

Since almost everything in life is relative, these charges and the savings that Medicare will realize by halting them must be taken in the context of other contemporary medical fees. How many keratoses can be removed, for example, in place of a transurethral resection of the prostate, or a cataract extraction, or a total hip replacement? While most people would argue that these surgical procedures are much more important for the patients' well-being, such decisions are sometimes highly subjective and arbitrary. What about colonoscopy or arthroscopy or coronary angiography? Are these always more important than the removal of benign skin lesions although hundreds of lesions could be removed for the cost of just one of these procedures? These procedures, in addition, are performed on relatively small numbers of patients, while almost all elderly people, each one a taxpayer, has one or more benign skin lesions that may cause itching, distress, or embarrassment.

In England, committees of physicians and lay representatives still function to determine who shall get renal dialysis, and who shall die for the lack of it. I am uncertain whether English dermatologists are prohibited from removing benign skin lesions, and perhaps they are allowed to do so without any additional compensation from the government in their non-fee for service system of care.

If we start rationing the surgical procedures utilized to remove benign skin lesions in our wealthy nation that honors freedom of choice, the right of the individual, and the power of the dollar to purchase anything and everything, what we will ration next? The government has already rationed first and second trimester abortions and contraceptive devices by withdrawing public funds for such procedures and planned parenthood centers. This is the result of a philosophic decision by government leaders to allow middle class-paying patients to obtain these procedures while preventing those who are federally subsidized from obtaining them.

What about TURs? Why is it necessary to have elderly men urinate easily, or have those who have been injured have their knees examined, or have cataracts removed so the elderly can read or drive? The ultimate rationing will come when society ultimately will deny all medical care to patients, saving on the cost of everything except for the funeral expenses.

Other dermatologists have been subjected to similar audits and harassment as the physician I describe. They have also been accused of overutilization, and have been asked to repay hundreds or thousands of dollars for patient care procedures which were never prohibited or rationed in the first place. At a meeting of the Miami Dermatological Society last year, we discussed this foreboding trend,and one member suggested that dermatologists themselves should begin to ration the surgical removal of benign lesions by informing patients that these lesions may not be covered by Medicare, and since they are benign, the patient will have to pay for them directly without any chance of Medicare reimbursement. Most of the members present spoke critically of such a policy, believing that it will only accelerate our decline into an abyss of poor quality patient care, rationing, and different levels of care based on a patient's willingness and ability to pay for procedures.

If we extend this proposed concept, then ultimately our health care system will become totally corrupted by money and power. Surgeons at some future time will have to inform patients that they cannot have coronary bypass surgery unless they are willing and able to pay the $50,000 required without Medicare reimbursement. Will our society too have a committee to decide who will live and who will die, while we spend $350 billion for the Department of Defense and billions on foreign aid?

I read recently that the average family in Hong Kong spends 40% of its available income on food because the Chinese citizens of that city value fresh ingredients and good cuisine so much. We spend a

billion dollars a day on health care in this nation, about 11% of our Gross National Product, but is that really too much? We are a nation that values health, cleanliness, physical fitness, and the individual's rights to comfort, dignity and all that is possible to prolong life and limb.

We must stick together to prevent the health carepayers, like Medicare, from attacking us one at a time. Under the guise of limiting our incomes, they will be attacking our patients and the health care delivery system which caters to the right of the individual to obtain personalized and high quality health care. We must maintain strength through the FMA and our county medical societies, and through our specialty societies. United we shall endure, alone we shall succumb.

● Dr. Feinstein, 3661 S. Miami Ave, Miami 33133.



to STEAMBOAT

For a MEDICAL/DENTAL Seminar

Meetings* are scheduled weekly in Steamboat Springs, from December 10th through April 14th and are approved for AMA, Category 1.

For information call: 800-525-3402

or write to:
ASSOCIATION FOR CONTINUING EDUCATION
P.O. Box 774168
Steamboat Springs, Colorado 80477

*Programming meets IRS requirements for deductibility if the primary reason for attending is educational/professional.

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

THE MEDICAL SYSTEM INCLUDES:
- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

ADVANTAGES
- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

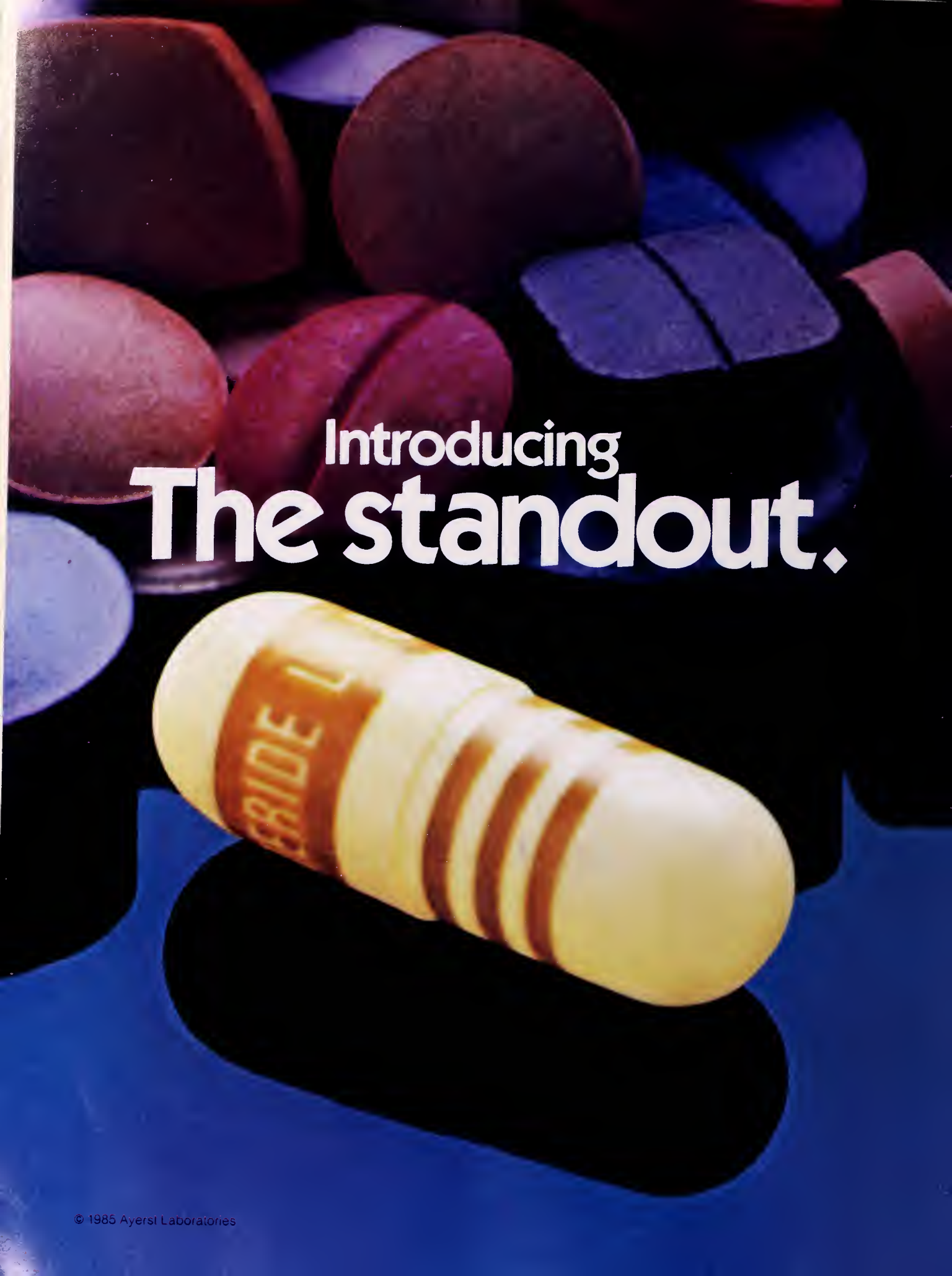
INTERESTED?
For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

The ISI Software Question

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.


Among so many once-daily
antihypertensives,
only one can offer so much...



© 1985 Ayerst Laboratories

Once-daily INDERIDE® LA

The world's leading beta blocker and diuretic—for once-daily convenience without compromise

When selecting other once-daily agents, physicians may have to compromise either their choice of beta blocker or diuretic. With INDERIDE® LA, physicians have the agents most widely prescribed worldwide—INDERAL® and hydrochlorothiazide—with the convenience of once-daily dosage.

24-hour blood pressure control with the broad benefits of INDERAL (propranolol HCl)

The controlled-release delivery system of INDERIDE LA provides 24-hour beta blockade and the broad cardiovascular benefits of INDERAL with a single daily dose. Compliance is enhanced because once-daily administration fits easily into patients' daily routines.

Plus standard-release hydrochlorothiazide, the thiazide of choice for comfortable morning diuresis

Hydrochlorothiazide is the world's most widely prescribed antihypertensive diuretic. When taken in the morning, INDERIDE LA provides comfortable morning diuresis. Each dosage strength of INDERIDE LA contains:

—one of the three most widely prescribed dosage strengths of INDERAL® LA—80 mg, 120 mg, or 160 mg and

—an established, effective daily dose of standard-release hydrochlorothiazide—50 mg

New once-daily

INDERIDE® LA

Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg

Convenience without compromise



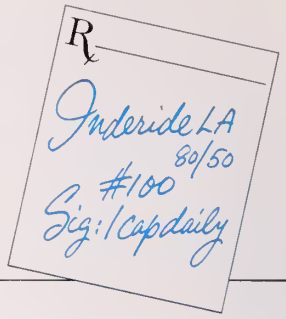
80/50 120/50 160/50*

*The appearance of INDERIDE® LA Capsules is a registered trademark of Ayerst Laboratories

Please see following page for brief summary of prescribing information.

Once-daily
INDERIDE® LA
Convenience without compromise
One capsule—Once daily





* The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERIDE® LA Brand of **PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE (Long Acting Capsules)**

No. 455—Each INDERIDE® LA 80/50 Capsule contains	
Propranolol hydrochloride (INDERAL® LA)	80 mg
Hydrochlorothiazide	50 mg
No. 457—Each INDERIDE® LA 120/50 Capsule contains	
Propranolol hydrochloride (INDERAL® LA)	120 mg
Hydrochlorothiazide	50 mg
No. 459—Each INDERIDE® LA 160/50 Capsule contains	
Propranolol hydrochloride (INDERAL® LA)	160 mg
Hydrochlorothiazide	50 mg

INDERIDE LA is indicated in the management of hypertension

This fixed-combination drug is not indicated for initial therapy of hypertension. If the fixed combination represents the dose titrated to the individual patient's needs, therapy with the fixed combination may be more convenient than with the separate components.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL®):
Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol

Hydrochlorothiazide:
Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

WARNINGS

Propranolol hydrochloride (INDERAL®):
CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patients should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide:
Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL®):
GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease; elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide:
GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL®):
Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:
Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

5112/985

Ayerst® AYERST LABORATORIES
New York, NY 10017

Should Florida physicians embrace medical trade unionism?

The prophets of medical unionism have been preaching throughout Florida. The FMA membership needs some more information about unionism. I have assigned the difficult task of presenting the positive side of trade unionism for physicians to Thomas Scott Jr., M.D., a neurosurgeon in Volusia County. I have rebutted his points and have attempted to augment the editorial written by Dr. Lacsamana in the September 1985 issue of The Journal of the Florida Medical Association, Inc.

Why we need medical unionism

The rising discomfiture of physicians brought on by the turbulence in medicine makes consideration of unionism for doctors an attractive remedy for tranquilizing our anxieties. Physicians are now disorganized. They practice as individuals or in small groups and demonstrate no cohesiveness. Without organization and a unified voice, they have no opportunity to influence the changes that are altering medicine. These changes require ethical and quality standards that we have inherited from our professional ancestors and have taught to our younger colleagues.

The need for a specific organization that might act as a bargaining agent for the medical profession is urgent. This organization might be called a "union," "medical guild," or given some other title, but such an organization must be controlled by physicians and its membership must be limited to the physicians.

The goals of this organization should be multiple: first, it could help oversee and assure the quality of medical services given to the public. Quality will deteriorate as the ever-burgeoning number of underemployed physicians submit to contract medicine and become employees of HMOs and other institutions which are more concerned with "bottom line medicine" than patient welfare.

Secondly, a strong union could challenge and contain the disruptive distortions of the medical landscape that are being wrought by government and corporations. Physicians, government, and corporations are currently deadlocked in a struggle to determine who will control medicine. Physicians can emerge the victor only if they have a strong, unified organization to battle for them.

Thirdly, unions can prevent exploitation of physicians by employers. Individual physicians who agree to work for HMOs and PPOs can be victimized by the vicissitudes of the administrators of those organizations. A physician's contract can be terminated for being thorough and conscientious because practice of such quality medicine may brand him as an "overutilizer." Physicians can also be terminated when other doctors are willing to perform the same job for less money. Job security will be based on an acceptable pay scale rather than on physician skill and the quality of his care.

Fourth, a medical union might be able to induce changes in the tort law structure of the states. Changes such as limiting or eradicating the contingency fee system, limiting payments for the emotional aspects of the malpractice claims, limiting the concept of joint and several liability, and altering

the mechanism by which "nuisance suits" are handled are needed. A strong medical union may be able to impact more heavily upon legislators and thus implement these needed changes more rapidly.

Fifth, hospital administration has seized a larger role in the decision making process concerning patient care and will increasingly do more because of DRGs and other payment limitations. Physicians need some form of organization to buffet this additional incursion into medical practice.

Sixth, the application and availability of medical technology is being regulated by government fiat. A strong union can demand local physician input into the granting and distribution of certificates of need.

Physicians should seriously consider the urgent need for some type of organization which will represent them and provide them with a powerful bargaining agent. National, state and county medical societies are forbidden by law to serve this purpose. A medical union can provide a mighty force in our fight for survival of the quality care medical system that currently is present in this country.

Thomas E. Scott Jr., M.D.
Daytona Beach

Unionism: an inappropriate treatment for medicine's ills

Dr. Stanford Marcus expressed the opinion in his *New England Journal of Medicine* article that trade unionism for doctors is an idea whose time has come.[1] I disagree. Trade unionism is an inappropriate and untimely vehicle for resolving the current problems of physicians because of historical, social, economic, political, tactical and legal impediments.

A review of unionism's history and its application to today's socio-economic conditions provides an assessment of the low probability of success of trade unionism for doctors.

Trade unionism is primarily a European invention and has been more successful as an institution there than in the United States. At its peak of popularity, unionism in Europe had enrolled over half the eligible workers. This unionism fervor sprang from some rather harsh and primitive attitudes towards labor which developed during the Middle Ages. These attitudes granted to the State and to employers the right to establish maximal wages and to demand that eligible males work. Class resentments and distinctions which originated from accidents of birth, bondage, or legal privilege, ignited and fueled the passions that permitted unions to thrive, grasp power, and to change the common law as it was applied to labor. Unionism's intellectual and emotional thrusts in Europe were not directed solely towards improving the standard of living of the worker. Rather, European unionism also aimed to significantly alter and even to overthrow the social and political structures of that continent.

European labor culture contrasted sharply with that in the United States. Most inhabitants of America in the 18th and 19th centuries were highly individualistic people who looked upon themselves as self-determined and self-sufficient. They worked independently as frontiersmen, farmers and craftsmen. Except for the slaves, rigid class structures and were non-existent and fluid social and economic mobility was permitted. Sprouts of unionism did emerge in cities such as Philadelphia and New York in the late 18th century but these organizations rapidly wilted after a brief bloom.

As the industrial revolution accelerated within the United States, workers' living conditions deteriorated, violence arose at work sites, and an empathetic milieu for unionism became implanted. Nevertheless, trade unionism did not acquire powerful dimensions in America until the 1930s. As recently as 1917 only five percent of the labor force was unionized.

Three major events plowed away the final barriers to unionism's belated success in the United States. The first was World War I which tore asunder the political and social fabric of Europe; the second was the communist revolution in Russia whose egalitarian declarations tantalized the intellectuals and the press; and the third was the poverty engendered by the Depression. The compression of these cataclysmic events into the brief span of fifteen years subverted three supporting credoes of American economic thought that had survived since the American Revolution: that the rights of the corporation or employer superceded that of the workers

As recently as 1917 only five percent of the labor force was unionized.

because societal benefit would be possible only with corporate success; that the individual was responsible for and capable of improving his own well-being; and that government interference in or regulation of commerce should be absolutely minimized. The sudden upheaval in the assumptive world of Americans in the 1930s catalyzed the simultaneous interaction of economic, intellectual, judicial and political thought that resulted in tolerance of government regulation of business, in suspicion of corporate power, and in sympathy for

the goals of the labor movement. Legislative actions that excluded unions from antitrust and tax laws and that protected them from injunctions catapulted the labor movement into a prominent power position within American society. Within two decades, union membership expanded five-fold — from five to twenty-five percent of the working population.

Since the 1960s the union movement has peaked and declined. Membership has eroded from twenty-five to less than twenty percent of the working population. In 1980 unions lost seventy-five percent of 902 elections to decertify the union as the collective bargaining agent. Factors leading to the enfeeblement of unionism are several: the high costs of union labor has been blamed by some critics as a major contributor to the financial desperation of the U.S. heavy industry. Allegations of union corruption, the relative affluence of our population, the fact that most Americans do not recall the Depression, and a social and political philosophy that eschews the socialistic experiments of the 1930s to 1960s, have displumed unionism of its public sympathy and divested it of influence.

Justification for any consideration of physician trade unionism feeds upon the issues of power and domination of medicine.

When we reflect upon this historical backdrop, we can recognize that significant union power has been an anomaly of American history and is fading. Furthermore, there are few, if any, parallels between the forces that energized the union movement in the 1930s and the socio-economic conditions of today. Our society is politically and economically stable, rather than turbulent; the destitute and helpless status of the Depression workers that crystallized editorial and political sympathy certainly is not shared by the 1980s physician and socialistic idealism is no longer de rigueur in intellectual and political circles. Thus, the conditions that fostered unionism's ascent no longer exist but the forces enervating it expand each year. American society lacks the intellectual, economic and political forment that is necessary to nurture physician unionism. For physicians to espouse unionism during this period of its decay is folly.

Justification for any consideration of physician trade unionism feeds upon the issues of power and domination of medicine. How do we, as physicians, acquire power? How do we keep it? How do we wield it? Who is going to exert ultimate control over medicine? Government? Insurance companies? Corporations? Or doctors? Most doctors feel that their economic security can be preserved only if physicians maintain control of medicine. Physicians have belatedly acknowledged that control of the economics and politics of medicine is crucial to their interest. Today physicians still maintain this control but the force of their grip is ebbing.

Unionism is nothing more than a mechanism of obtaining and sustaining power. But the historical sources of the power of unions differ starkly from those of modern medicine. Reynolds has observed that unions derive their power not from the strike itself but from the ability of the strikers to prevent replacement laborers from working.[2] Labor disputes are fundamentally not conflicts between the workers and management, but are basically conflicts between organized and unorganized workers. The history of the union movement confirms this observation. The victims of labor violence and intimidation are other workers and rarely are owners or managers. Intimidation of non-union workers, not management, is the weapon that union employ. These facts are as true today in the fight over unionization of the grape pickers in California as they were during the violent railroad strikes of the 1890s. If we doctors embrace unionism, are we going to declare internecine warfare on our non-union colleagues?

Physicians derive societal power from different sources. Chief among these is public esteem. Esteem flows to us from our specialized knowledge and skills and the scientific methods and technologies we apply. The public's attitude towards physicians is like religious faith — faith in physicians' integrity, concern for the public health, and in the physicians' compassion and altruism. But public esteem, like faith, is a frangible icon that can be easily shattered. Our political power would be trivial without it. Realistically, we make up a small fragment of American society. Numerically, there are only 500,000 physicians — a number too small to mount any significant political or economic force when compared to the size of other groups, factions, corporation or interests. Our political strength depends upon sustaining our public prestige. Opinion polls indicate that unions of all American institutions reside upon the lowest rung of the prestige ladder, while physicians are still highly regarded. Politically, it seems unwise to dilute our public image by mingling it with unionism.

Actions inappropriate to the public welfare rapidly extinguish public esteem. The tactics of unionism are intimidation, coercion, violence, strikes, picketing, and boycotts. The tactics of organized medicine are public education, support of scientific medicine, support for scientific research, insistence on quality care, and a strident but legal denunciation of quackery. When organized medicine has battled, such as when it challenges the legitimacy of other health care practitioners, it has conducted its jousts in the courts and media and not in the streets or at the practice sites of its antagonists. The tactics of unionism are inappropriate to medicine.

Hopefully the deportment of physicians will remain closer to that of a white knight than that of a troglodyte.

Are there any tactics that an organized medical union could use that might be appropriate? Dr. Scott has stated that one weapon that might be employed is the refusal to complete the paperwork demanded of us. However, most of the paperwork that we complete, outside of medical records, is directed towards obtaining payment for our services. If we refuse to complete paperwork, we either financially injure or enrage our patients who will not be reimbursed, or we injure ourselves because we will be denied payment without it. There are very few instruments of unionism that we can find useful. Why then use a medical union as a collective bargaining agent?

Mr. William Adams, who is an outside counsel to the Florida Medical Association, has warned us that medical unionism probably violates anti-trust laws.[3] Anti-trust legislation specifically prohibits any attempt to "contract, combine, or conspire, to restrain trade." Collective bargaining by physicians is considered an attempt to restrain trade. If physicians organize and agree to fix prices or even agree to dictate the practice conditions under which we will function, then we legally restrain trade and violate the anti-trust laws. This is a criminal offense which can result in awards of treble damages for any economic losses to the plaintiff who wins an anti-trust suit. The legal system has previously demonstrated that county, state and national medical associations may not collectively bargain for its members. Physicians in private practice are definitely deprived from using any organization for the purpose of collective bargaining.

Unions are exempt from the anti-trust law and proponents of unionism have cited this exemption as a means of circumventing the law. Superficially this is a seductive strategy, but the thinking is specious. The law specifically states that only employees may use a union for collective bargaining. The law further defines employees. Physicians who work for HMOs, government agencies, or hospitals may possibly be considered as employees and might be able to unionize. But such physicians who act in a supervisory capacity as well as private practice physicians who are de facto employers, have no legal basis to use any organization for collective bargaining. Why then has the federal government not challenged the medical unions that have enrolled private physicians? Probably because existing unions are economically effete. As soon as union censuses swell so that market forcefulness becomes feasible, the risk of being smitten by the anti-trust forces will substantially increase.

Why look to unionism as a methodology of accomplishing our goals? Why adopt a system that is an historical anomaly and an anachronism, that generates public repudiation rather than support, that depends upon repugnant tactics for its success, and that is legally inappropriate to our status in society? Alternate methods of exercising our power exists. Some of these will be explored in the next month's issue of *The Journal.*

References

1. Marcus, S.A.: Trade Unionism for Doctors An Idea Whose Time Has Come, N.E.J.M., 311:1508-1511, 1984.
2. Reynolds, M.O.: Power and Privilege Labor Unions in America, Universe Book, New York, N.Y., 1984.
3. Adams, W.H.: Doctors' Union Concept Could Run Afoul of the Law, FMA Today, 1985.
4. Lacsamana, R.: Medical Unions. The Potential and the Pitfalls, JFMA, 72:747-749, 1985.
5. Kassalow, E.M.: National Labor Movements in the Postwar World, Northwestern University Press, 1963.
6. Dnaiels, W.M.: The American Labor Movement, H.W. Wilson Co., New York, 1958.

Jacques R. Caldwell, M.D.
Daytona Beach

Immediate Florida Practice Opportunity In . . .

NEUROSURGERY

We are seeking two (2) board certified neurosurgeons for the Florida office of a nationally-known group practice and multi-hospital system.

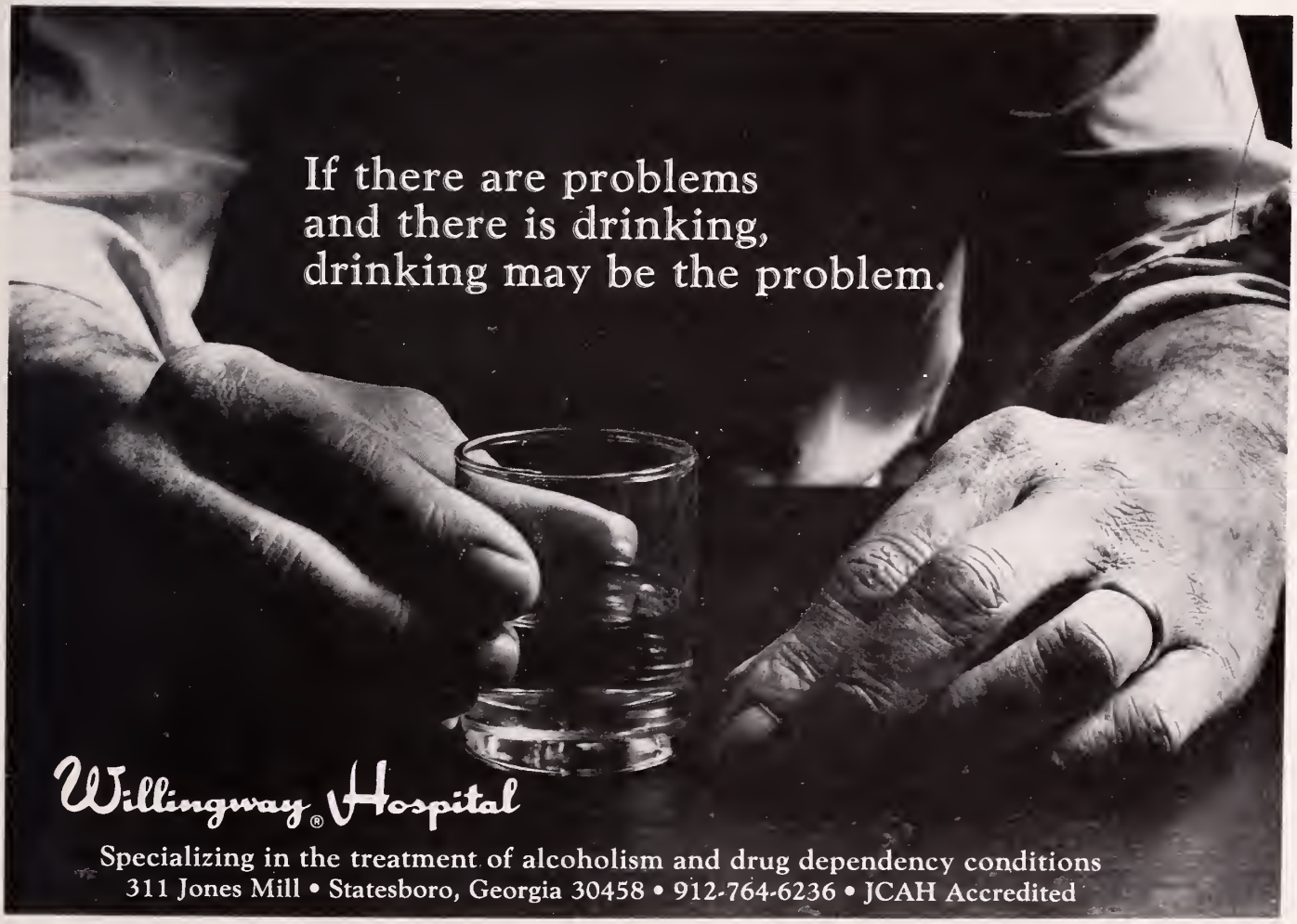
Candidates should have an exceptional record of clinical practice, a strong interest in continuing medical education, and a commitment to personal care in a group practice setting.

Prior teaching experience, professional publications and a current Florida license would be desirable.

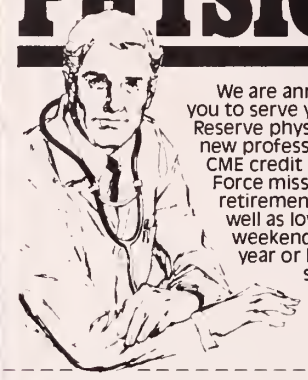
Physicians wishing to express an interest should send a cover letter with career objectives, and a complete curriculum vitae to:

Box # C-1322
Florida Medical Association
P.O. Box 2411
Jacksonville, FL 32203

All inquiries will be answered in confidence.



PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HQ 10 AF/RSH
Bergstrom AFB, TX 78743-6002

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Prior Service? Yes ___ No ___

Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE

The Answer

For Your Gift Giving Problems

Tired of sending the same old flowers and candy? This year, send your special someone the gift of health — a box of Florida sunshine!

They'll love the fruit . . . and you for sending it.

For Mother's Day
For Thanksgiving

F.M.A. Auxiliary
F.M.F.

Mrs. Gary Wright
4171 S.E. 38th Street
Ocala, Florida 32671
(904) 694-2248

FREE Gift Wrapping is available to personalize your order.

He Thought That Drinking Wouldn't Make Any Difference, Even Though He Was on a New Medication. But It Did.

Now he knows that alcohol and some medicines don't mix. In fact, more than half the 100 most prescribed drugs have at least one ingredient that can cause trouble if taken while drinking alcohol. The result of mixing these drugs (alcohol is a drug) may be no more than simple temporary illness, but some combinations can be dangerous, even deadly.

So, don't make a test tube out of your body. Be sure to tell your doctor or druggist about any medications you are taking and be sure to ask about the consequences of mixing a newly prescribed drug with alcohol.

Also, make it a habit to check the label carefully when you get a drug, whether it's a prescription or over-the-counter medication.

And when you get any prescription, be sure you know—

- **The name** of the drug
- **Its purpose**—what conditions does it treat?
- **How and when** to take the drug—and when to stop taking it
- What **food, drinks and other drugs to avoid** while taking it
- What **side effects** may result—are they serious, short-term, long-term, etc.?

If you have any questions about your prescription, *ask your doctor or pharmacist.*

A message from the Food and Drug Administration. For more material about being an informed patient, write to: FDA, HFE-88, Rockville, Md. 20857.



FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 129
- ☐ DEAN'S MESSAGE, 131
- ☐ ENCORES!, 132
- ☐ SCAM OF THE MONTH, 134

NOTES & NEWS

Joint Commission makes substantial change in standards development process and monitoring process

Over the past few years, the development and revision of Joint Commission standards have been guided by several principles. These principles require that: standards relate to quality of care and the safety of the environment in which care is provided; standards represent a consensus of experts on the state-of-the-art; standards state objectives to be achieved and not process; standards describe aspects of care or related functions that are surveyable; and standards are reasonable.

In the period since the implementation of standards guided by these principles, the Joint Commission has had the opportunity to gain experience with these types of standards. Although they have proven to be beneficial and effective in helping to upgrade the quality of care, these more flexible standards are also more complex for facilities to implement and the Joint Commission to survey. As a consequence, new approaches are being taken in the standards development and facility accreditation processes. With regard to standards development, the fact that some new standards have longer learning curves and require extended timelines for effective implementation has been recognized. Coupled with this is the need for the Joint Commission to better educate its surveyors to provide more consultation and consistent interpretation of the standards, as these standards require more judgment on the part of Joint Commission surveyors. Better educational examples are also required to assist organizations in the development of the new systems they implement in response to the standards. The new standards development process is also intended to identify in advance questions that may be asked concerning the implementation of new standards. The Joint Commission will develop responses to these questions and will make them available to the field.

With regard to accreditation decisions, the Joint Commission has reviewed the impact of the three-year accreditation award cycle, and has found that more time is required for the successful implementation of some standards changes. Factors such as the complexity of the standard and the implementation process, staff education and training have often contributed to an organization's inability to be in substantial compliance with certain new standards within the specified timeframes, even though steady progress is being made.

Because of the length of time required to implement certain key standards, the Joint Commission sought to develop a system which still acknowledges the necessity of full compliance with new and revised standards, but allows accredited organizations the time necessary to gain experience with and implement designated Joint Commission standards. This new approach, called Implementation Monitoring, comes as a result of the Joint Commission's better understanding of the obstacles to implementation, and affords the Joint Commission the opportunity to develop supportive and educational materials to assist organizations in achieving compliance. Flexibility is a central element in the Implementation Monitoring status.

Implementation Monitoring will pertain only to those standards designated by the Accreditation Committee of the Board of Commissioners. Any new standard which requires an extended period of time for implementation may be included in this category. Implementation Monitoring will take effect with surveys conducted after December 31, 1985. Interim measures have been adopted in order to deal similarly with organizations accredited between September, 1985 and the first presentation of January, 1986 surveys to the Accreditation Committee.

Organizations found to be in less than substantial compliance with standards that have been designated for Implementation Monitoring status will submit a report in 18 months outlining the progress being made toward compliance. The Joint Commission will let facilities know the type of information that it needs to review progress. Although the Implementation Monitoring status is not a contingency status, the penalty for failure to provide a report would be an attachment of a contingency on the organization's accreditation status.

The Implementation Monitoring status will not replace or eliminate necessary contingencies, nor will it lessen the importance of full compliance with Joint Commission standards. Rather, the Implementation Monitoring status will be used as an adjunct

in awarding accreditation decisions. Contingencies will continue to be placed upon an organization's accreditation status when key elements of existing standards requirements have not been successfully met.

Among the standards currently approved for Implementation Monitoring status are the new drug usage evaluation standards which were approved by the Joint Commission Board of Commissioners at the August, 1985 meeting. These have been placed into Implementation Monitoring status from January, 1986 through June, 1987. Other areas of the standards that have been placed into Implementation Monitoring from January, 1986 through June, 1987 include portions of requirements for clinical privileges (pertaining to peer recommendations); medical staff monitoring functions (pertaining to department review and use of clinically valid criteria for monitoring and evaluation); quality assurance (pertaining to use of medical staff quality assurance findings); and quality and appropriateness review (pertaining to support services).

The standards approved for placement into Implementation Monitoring status are discussed in greater detail in the November/December, 1985 edition of *JCAH Perspectives*, the official newsletter of the Joint Commission.

Medical education and physician supply in the South: Dramatic changes and challenges

- Since 1965, 14 new medical schools have been established in the South.
- Unlike 25 years ago, a large majority of the graduates of Southern medical schools are now remaining in the South to practice.
- Physicians are moving to the South in record numbers, about 1,500 each year. That is the equivalent of the graduates of 11 good-sized medical schools.
- So, in 20 years the South has added the equivalent of 25 medical schools and completely reversed the flow of physicians out of the region.

This is but a part of the dramatic evidence of the changes in medical education in the South. If one could step back 25 years and view these changes, they would have to be considered extraordinary. While it is true that there are still shortages of physicians in rural areas and too few minority physicians, these problems do not alter the fact that major, fundamental changes have occurred in medical education.

These dramatic increases in the numbers of physicians carry a price — a substantial cost for education and even larger costs for the services provided by these physicians.

A state invests $150,000 or more for each physician over the seven to eleven years of medical school and residency training. Conservative estimates are that each physician generates $250,000 per year in health care charges. Even without inflation that means each physician is responsible on average for at least $7.5 million of health care charges in a 30-year career.

There are more than 100,000 persons today being educated as physicians in the United States; more than a third of them in the South. These persons are in a "medical education pipeline" which is at least seven years long (four years of medical school plus at least three — in some specialties seven — years of residency). This medical education pipeline cannot be turned on and off like a kitchen faucet. A change in policy today would have little or no effect before 1990; more realistically it would be closer to 1995.

It is not popular to be concerned about success, but the rapid growth in numbers of physicians and dollars related to their education and practice does — or should — raise questions. These questions are not limited only to medical education, which is spotlighted here. The circumstances and answers to questions about future health professions education will differ from state to state. But the consequences for states are too important to let decisions about health professions education be made by simply drifting along on the same course as in the past 20 years.

In the next several months the Southern Regional Education Board will be putting health professions education and services questions before state policymakers in a series of articles and conferences. A report on *Supply and Distribution of Physicians in the South* is the beginning of the series. Copies can be obtained from SREB, 1340 Spring Street, N.W., Atlanta, Georgia 30309.

Southeastern Conference on Addictions

For physicians who want to know more about the disease of chemical dependency and its effects on the family, there is an exciting and informative national conference coming up in March, 1986, to be held at Hyatt/Palm Beaches, in West Palm Beach, Florida. The theme is *The Chemically Dependent Family*, and it is sponsored by the Center for Recovery at JFK Hospital and co-sponsored by The American Medical Society on Alcoholism and Other Drug Dependencies, Inc. The subjects to be discussed include "Co-dependency: The Hidden Illness," "Professional Re-Entry, Follow-Up and Aftercare," and "Grieving in the Alcoholic Family: Breaking the Cycle of Unfinished Business," as well as other topics pertinent to the physician's specific

interests. Twenty-three lecturers are scheduled to speak during the four-day conference, including Roger Goetz, M.D., Medical Director of the FMA/FMF Impaired Physicians Program; G. Douglas Talbott, M.D., Director of Chemical Dependence Treatment of the Ridgeview Institute, and Billie Wilson, C.A.C., Aftercare Therapist for the Center for Recovery at JFK Hospital.

The conference will be held March 16, 17, 18, and 19, 1986, with Sunday, March 16, being Physician's Day. Physician's Day meets the criteria for seven hours of the Physician's Recognition Award of the American Medical Association. For more information please contact U.S. Journal Training, Inc., 1721 Blount Road, Suite #1, Pompano Beach, Florida 33069.

DEAN'S MESSAGE

The clinical clerkship: an endangered species

The clinical clerkship, usually in the third year of Medical School, has had the solidarity of the Rock of Gibraltar amid what otherwise has been the swirl of curricular changes. Clerkships are in part a response to the Flexner Report, but more directly a legacy of the tradition of Osler, stressing the importance of teaching at the bedside rather than in the lecture hall. They have been with us for so long that every currently practicing physician, trained in the United States, received his or her introduction to the clinical practice of medicine as a clinical clerk. Time and the tides have finally caught up with the clerkship and it has now become a curricular problem.

Its constancy (or perhaps more accurately its rigidity), which for years has been its virtue, is gradually becoming its undoing. In the past the patterns of medical practice have changed with the gradualness of evolution, but more recently with the abruptness of revolution, and they have changed in ways beyond the accommodation of the clerkship. The experience as a clinical clerk is rapidly becoming incomplete and inadequate.

The clerkship has always been a hospital based experience. In the days when much of the meaningful health care could only be delivered in a hospital setting, this placed the clerkship at the focus of the action. The clinical clerk stood an excellent chance of following a patient with a simple medical problem through the processes of diagnosis and treatment. Those were halcyon times, at least from the standpoint of medical education, when patients required admission for the treatment of severe congestive heart failure in mitral stenosis, pneumonia, inguinal hernia repair and cataract extraction.

It is clearly in the patients' best interest and in the best interest of society as a whole that mitral valves be replaced, patients with pneumonia get penicillin and be sent home, and hernias and cataracts be repaired as outpatients. But from the stand point of the clerkship something has been lost, and without a good mechanism for its replacement.

These problems are compounded by dramatic changes in the Academic Medical Center. Open wards filled with indigent patients have been replaced with semi-private rooms occupied by referrals who seek access to advanced technology and highly specialized care. In all hospitals as much of the evaluation as is feasible is done before admission. Our government, directly or with indirect but no less effective pressure, demands the shortest possible inpatient stay, with the result that the patient passes the clerk as a blur with little chance for the clerk to observe or learn the natural history of an illness and its management.

A natural response would be to initiate an outpatient clerkship and fill in the blanks. Although this has been tried and tried again, it has never become comfortably successful. There are two high hurdles that seem to cause most of the falls. First, few faculties have had the courage or the necessary unanimity to add a curricular requirement that will place a student in the ambulatory teaching setting for the three months that seem to be necessary to permit patients to be followed through disease evolution. The common half day each week has not been a successful solution, largely because of the difficulty of scheduling the patients' health care at the times of limited availability of the student.

There is a second difficulty associated with moving a student clerkship into the office. The patient admitted to the hospital is constantly available to the teaching service. Even the most strenuous inpatient evaluation takes the patient away from the bed for only brief intervals of time. The clinical clerk is able to obtain a detailed history, and, if necessary, plod through a complete physical because the patient is there in the room all day long, student or not. Efficiency is measured in days of hospitalization not hours. In the office setting it is customary to use 15 minutes as the unit of time for determining the efficiency of the use of an examining room. No outpatient teaching service involving students can operate as efficiently as a nonteaching practice. There is a real teaching cost that we are not yet budgeted to meet.

The problems with the clerkship are emerging but not yet acute. It is likely that they will survive just as sharks have survived through geologic time. At the same time it is sobering to note that the Great White Shark (Carcharodon carcharias) is a mere

shadow of Megalodon the giant shark of prehistoric seas. Survival is likely at the cost of significant change.

William A. Sodeman Jr., M.D.
Deputy Dean for Academic Affairs
University of South Florida
College of Medicine
Tampa, Florida 33612

ENCORES!

The Hippocratic Oath — corporate version

To the Editor: Lecturing recently in our medical-ethics class, I discussed what I regard as the several good and important ethical sentiments of the Hippocratic Oath. Some of the students expressed the opinion that the oath is so outdated it now has no relevancy.

Sadly, I turned to the task of devising this modernized version of the oath:

I swear by Humana and the American Hospital Supply Corporation and health maintenance organizations and preferred-provider organizations and all the prepayment systems and joint ventures, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold the one who has taught me this business as equal to my corporation president, and to live my life in partnership with him, and if he is in need of capital to give him some of mine, and to regard his offspring as equal to my colleagues and to teach them this business — if they desire to learn it — for a fee and under contract; to give a share of my practice-management techniques and computer systems and all other business acumen to my children and the children of those who have taught me, and to students who have signed the contract and have taken an oath according to Medicare law, but to no one else.

I will apply dietetic measures for the benefit of the obese, the alcoholic, the smoker, and the drug addict, but because these days everyone has the right to do his or her own thing, I will seldom be able to keep them from self-harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor make a suggestion to that effect. Similarly, as an internist, I will not perform an abortion. In fear of malpractice I will guard my life and my business.

I will not use the knife unless I am a surgeon, but I will try to learn some form of endoscopy.

Into whatever clinics I may enter, I will come for the benefit of the insured, keeping myself far from all except capitated care for the underprivileged, especially if they are not covered by the group contract.

Things that I may see or hear in the course of treatment or even outside treatment regarding the life of human beings — things that one should never divulge outside — I will report to government commissions or administrators, or will use in my book.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and business, and to be able to retire at the age of 50 in the Sunbelt; if I transgress it and swear falsely, may Milwaukee be my lot.

David L. Schiedermayer, M.D.
Medical College of Wisconsin
Milwaukee, Wisconsin

Reprinted with permission from *The New England Journal of Medicine*, January 2, 1986, page 62.

Heinz Report bares DRG flaws: recommendations compound them

Approximately two years after the institution of a national Medicare prospective payment system, the first significant study of its impact on the quality of care has become available.

The Staff Report of the U.S. Senate Special Committee on Aging was published in late September. Chairman Senator John Heinz has been widely quoted about the impression that patients were being discharged "quicker and sicker."

Those of us who warned unsuccessfully about the predictable shortcomings of DRGs and the lack of feasible quality control had been dismissed from consideration because of insufficient provable documentation of our charges. DRG incentives to withhold or limit quality care and PROs, initial disinterest and later inability to address these issues provided the major basis of our objections.

The "Heinz Report" gave promise of supplying the long-sought confirmation of our criticism, and to a large extent did exactly that:

- Inflexibility of DRGs made no allowance for severity of illness, nor for psychological and socioeconomic factors.
- Diagnosis-based reimbursement invited "creative" diagnosis and "fictional" chartkeeping.
- Bureaucratic ineptitude was illustrated by characterization of HCFA as the source of "vague, confusing, and conflicting information."
- Hospitals with limited reimbursement must balance costs of compliance with regulation and appeals processes by cutting patient-related expenditures, and pressuring the physicians to let cost considerations overrule good medical judgment.

- PRO stress on utilization review for cost control has been at the expense of quality assurance.
- "Peer review" by nonpeers (nurses, GPs, etc.) leads to a high percentage of appeals. At great cost to all involved in terms of time, money, and paper, reversals of appealed rulings are in the range of 50%. Such inaccuracy is unjustifiable.
- PROs lack the funding, personnel, or capability needed to give more than lip service to the quality-of-care issue.
- Unawareness or inability to register complaints on the part of patients is a major factor in the underreporting of "horror stories" and the failure of appropriate relief.
- Inadequate or unavailable intermediate nonacute care continues to be an unresolved problem.
- Hasty implementation of the program without adequate resolution of the obvious gaps and predictable shortcomings has created a real and present danger to the aged and infirm.

So much for the good news. Now for the bad news. The report is accompanied by a list of 10 recommendations, which leave much to be desired. They range from the redundant to the ridiculous. The most alarming aspect of the recommendations is that implementation would require large amounts of additional funding, little of which would relate directly to providing adequate health care.

Highlights of the recommendations and my analysis follow:

- Adjust DRGs to better reflect differences in severity of illness between patients in the same DRG category.

Correction of this major original shortcoming should make the program less bad, but multiplying present DRGs by a factor of three, four, or five would further complicate an already overly complex system.

- Remind Medicare-certified hospitals of the illegality of discrimination on the basis of diability and prosecute via the HHS Office of Civil Rights.

Gross violations already qualify as malpractice. Adding Civil Rights considerations would merely add Constitutional litigation as a nonproductive cost increase.

- Revise PRO scope of work to require comprehensive quality assurance monitoring and enforcement activities.

Akin to legislating morality, with a comparable chance of success.

- Pass S. 1623, which would authorize PROs to deny payment for substandard care and help PRO financial viability.

PROs, like their predecessor PSROs, share the customary track record of governmental bureaucracies for cost inefficiencey. This attempt to make bounty hunters out of the PROs would only focus attention upon the already disturbing conflict-of-interest issue.

- Authorize and appropriately fund large-scale quality review.

Logistically impractical, and fiscally exorbitant. The issues in determining the quality of health care are too involved and too individual to permit abstract evaluation via computers and marginally knowledgeable reviewers.

- HHS should require a clearly defined apppeals procedure for grievances, and inclusion of rights and responsibilities under DRGs in Medicare patients' informed consent forms.

Grievance mechanisms already exist. Additions to consent forms would not ensure patients' understanding, or ability to respond.

- Expand existing laws to allow payment to hospitals when no appropriate posthospital placement can be found.

This sounds reasonable, but if requirements for approval are as demanding as current criteria when nursing home beds are lacking, we will reap little more than snarled red tape from the process.

- PROs should extend quality assurance to a percentage of hospital-discharged patients through the continuum of care in nursing homes, home health, and other programs.

Prior expensive studies have been all but invalidated by failure to do such follow-up. This proposal would either cover an inadequate number of cases, or require massive funding — far better applied to the holes in the safety net.

- Congress should create within each state a Consumer Advisory Board (CAB) to conduct oversight of the PROs.

Any such board must have a minimum of 51% of members who qualify as consumers. By definition, anyone involved in the provision of health care (and therefore knowledgeable on the subject) is excluded from the category. With little more than an insatiable appetite as qualifications, such groups have wrought major havoc in many areas of the economy. Most of the individuals involved represent self-interest lobbying groups. To recognize them in an overseeing capacity simply adds another layer of bureaucracy.

- Congress should authorize the creation of an interagency panel to seek out quality problems and develop criteria for a uniform quality of care review system.

Another redundant committee concept approach. Any output is far more likely to be political, rather than practical.

In summary, the report lends credibility to the concerns of those of us who honor our responsibility to be the ultimate patient advocate. Regardless of the seemingly good intentions, third party intervention between the doctor and patient substitutes

someone else's criteria of acceptable health care for that of the person involved.

Many reputable authorities evade the issue by claiming that we have yet to define quality of care. Conceding it to be a relative term has not prevented me from, in any given instance, being able to characterize it as good, bad, or mediocre.

Since bureaucratic programs are at best mediocre, we should do everything in our power to prevent them from establishing standards. Prevailing egalitarian concepts of equality would make mediocrity the intermediate goal, while striving for the only absolute degree of equality: at point zero.

Frank J. Primich, M.D.
The Meadowlands, New Jersey.

Reprinted with permission from *Medical Tribune*, November 27, 1985, page 34.

Legislators can't avoid crisis in insurance in 1986 session

Florida has displayed a fair amount of ingenuity in defusing prior insurance crisis but the one that will come before the 1986 legislative session may be the most vexing.

In the mid-1960s, the Legislature was casting about for a way to stop the escalation of automobile insurance rates and the decreasing availability of auto insurance. It finally cured the crisis with no-fault after another treatment only aggravated the situation.

The Legislature first tried the so-called California plan, which either allowed or caused the situation to worsen to the extent that it sent the insurance commissioner at the time down in electoral defeat, despite the fact that he was more of a bystander than a participant in the effort to install the California plan.

Then the Legislature settled upon no-fault, which held rates down even if it did so, at least partly, by reducing the protection enjoyed by policyholders.

Another significant crisis that arose during the 1970s in the field of workers' compensation was ameliorated by an overhaul of the law.

The persistent trouble area since then has been in professional malpractice insurance, most especially medical malpractice.

Some steps were taken that seemed to turn down the volume of complaints but they eventually either broke down for various reasons or were thrown out in court.

Now, a combination of events — some of them having nothing to do with Florida law — have come together to create another full-blown insurance crisis that is broad-based because its effects are not confined to any particular profession or class of premium payers among casualty insurance customers.

Unless some wisdom is applied in advance of the session to diagnose the real trouble areas and try to fashion remedies, the probable outcome will be a clash of the various financial interests on each side and a Pyrrhic victory for one or the other, as the California plan turned out to be, or else a stalemate and the status quo.

A powerful group called Project Civil Reform Inc. is seeking an overhaul of Florida's tort system — the legal arena where damages are determined and assessed — as well as national changes. The group, composed of insurance-industry trade organizations, Florida business and professional groups, the Florida League of Cities and private businesses, says in a news release that:

"In Florida. . .(the) tort system makes almost all international reinsurers unwilling or unable to invest their limited reinsurance capacity in Florida. The Florida experience is succinctly stated by Sister Irene Kraus, president of St. Vincent's Hospital in Jacksonville. According to Sister Irene, the Lloyd's underwriters told her just last month that they are unwilling to commit capacity here until Florida undertakes significant tort reform."

Among the changes being sought by the group in Florida is law overturning the court doctrine of joint and several liability, which makes each party found at fault liable for payment of the entire amount of damages — no matter what their degree of liability.

Instead, the organization seeks a law that would apportion liability payments to the at-fault parties according to their degree of blame and leave it up to the aggrieved party to collect from each separately.

This change is opposed by Florida's trial lawyers and other groups who say it would leave many individuals who are damaged by the actions of others largely uncompensated for their injuries.

In the middle of this battleground of competing interests will be the legislators charged with sorting out the issues and putting the public interest into any suggested solution.

Nobody says it will be easy. But past achievements indicate that it can be done. Floridians have an enormous stake in its being done well.

Reprinted with permission from *The Florida Times-Union*, January 24, 1986.

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"Asleep at the wheel scam"

The old Narcolepsy scam is still with us and appears to be gaining in popularity due to the dramatic decrease in the prescribing and dispensing of AMPHETAMINES for weight control by Missouri's physicians (due to the new directive from the Board of Healing Arts). Now, with weight control being a very limited source of "speed" for "Professional Patients" they are feigning Hyperactive or Narcoleptic symptoms. It is difficult for most persons over 17 years of age to be Hyperactive, so faking Narcolepsy is the ruse in vogue.

Investigations in all parts of Missouri have revealed that there are several "Professional Patients" traveling statewide on a regular schedule and seeing the same group of doctors month after month. One such individual would present himself to each physician with a very convincing story and would actually fall asleep while talking to the doctor. He had read all of the medical journal articles dealing with Narcolepsy and sounded very convincing. This individual specializes in DESOXYN.

Another gives each physician a local address and usually tells the story that he is in the middle of a divorce and is traveling back and forth to Colorado where he hopes to find employment. In Kansas City and St. Louis he tells physicians he is employed at either General Motors Assembly Plant or the Ford Motor Company Plant. This individual specializes in RITALIN.

This individual has documents from a hospital in Oklahoma City indicating he was diagnosed as a Narcoleptic and indicates he had seen a number of physicians who verified this condition. Physicians who became suspicious of this individual quickly found out that the medical records were fake. When checking with the hospital, many of the doctors who confirmed the Narcolepsy were found not to exist.

Caution • The importance of making your own diagnosis and verifying any medical records with the doctor or hospital cannot be overstressed. Likewise, knowing the correct identity of your patient and the correct address helps to prevent the diversion of Controlled Drugs to illicit channels.



Rx for fine dining.

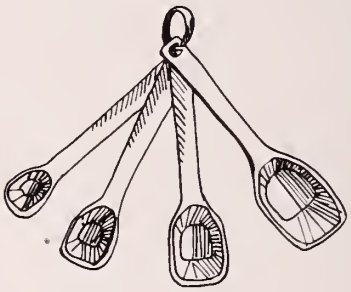
—A collection of over 700 gastronomical delights.

—Eight sections from appetizers to desserts - including many outstanding game, seafood and sauce recipes.

—Full color cover with original pen and ink illustrations dividing the sections.

—Spiral bound and indexed with menus, helpful hints and potpourri.

—Compiled by the Florida Medical Association Auxiliary for the benefit of health related projects.



KEY LIME PIE

"This tried and true recipe is best with a graham cracker crust It's easy and can be done ahead!"

4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored Blend in condensed milk Add lime juice, mix well In a large mixing bowl beat egg whites and cream of tartar until foamy Continue beating, adding sugar 1 tablespoon at a time until egg whites peak Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown Best served chilled May be frozen and kept for a couple of days before serving

*You can make the meringue with only 4 egg whites from the eggs you've used

Mrs Michael John Murray (Candy)
Lee County

Rx FOR FINE DINING
P.O. Box 2411
Jacksonville, FL 32203

Please send me _____ copies of Rx For Fine Dining at $10.00 per copy plus $1.30 for postage and handling. Florida residents add $.50 sales tax.

Make checks payable to — COOKBOOK PROJECT, FMA-A
P.O. BOX 2411
JACKSONVILLE, FL 32203

Name _____

Address _____

City, State, Zip _____

COOKBOOKS MAKE GREAT GIFTS!

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Chemical dependency

Chemical dependency — an epidemic in our land — is a devastating disease. It is a family illness, but affects everyone. For every chemically dependent person (alcoholic/addict) it is estimated that there are five other persons directly affected.

Chemical dependency is a progressive, but treatable disease. Without help the disease becomes fatal, and the addict will die. Likewise, those directly affected by the disease become part of the cycle.

Persons who love and/or live with a chemically dependent become co-dependent. A co-dependent is one who becomes so obsessed with, or focused in on another person, so as to lose all sense of self. An addict is addicted to the drug; the co-dependent is addicted to the addict.

Co-dependency is also a progressive, but treatable disease. Without help the co-dependent will live in dysfunctional misery and disillusionment. Destructive patterns will be repeated, and the co-dependent will possibly face death.

The core components of the disease of chemical dependency are delusion and disillusionment; the core components of the disease of co-dependency are the same. The disease becomes the "hidden illness." These hurting people turn up in doctors' offices presenting symptoms of stress-related illnesses such as arthritis, heart disorders, migraine headaches, ulcers, colitis, high blood pressure, hypersensitivity, and floating anxiety. Slowly, but surely, the co-dependent becomes as dysfunctional as the chemically-dependent, often without knowing what is happening to him/her.

The drug user's illness touches everyone close to him/her. Most affected are the parents, spouses, siblings, and children. Their thinking and their emotional balance become distorted. Interaction between user and family very often becomes destructive. Frightening demands are frequently placed on the resources of family, friends, the professions, health agencies, and the community. What a challenge to the physician!

It is vital that health care professionals recognize the presenting symptoms of the hidden illness of co-dependency and address the needs of those suffering from chemical dependency and co-dependency. This important step promises to be a potent tool in prevention, and in treatment of the chemically dependent family.

Al-Anon and Nar-Anon, self-help recovery programs based on the Twelve Steps of Alcoholics Anonymous, offer help for family and friends of alcoholics and addicts. Members give and receive comfort and understanding by sharing their experiences, strength, and hope in a caring atmosphere protected by the policy of anonymity. A number of physicians suggest faithful and regular attendance in order to help the co-dependent person to learn to live a more serene, productive, and healthy life.

For physicians and others who want to know more about the disease of chemical dependency and its effect on the family, a national conference will be held in South Florida, March 16-19. For more information, see the Notes and News section of this month's *Journal.*

Mrs. Clifford B. (Nancy) Miles
FMA Auxiliary Substance Abuse Chairman
FMA Substance Abuse Committee
Florida Cocaine Task Force
Pompano Beach

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

29 Glen Cove Ave., Glen Cove, N.Y. 11542 516-676-4300

Our members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
American Health(10)	14.95	12.95	11.95	
American Heritage(5)	24.00	18.00	18.00	
Amer.Photographer(12)	19.90	9.95	6.65	8
Americana(6)	11.95	11.95	9.95	
ArtNews(12)	29.95	25.95	25.95	
Artist's Mag(12)	21.00	21.00	9.97	9
Atlantic Monthly(12)	9.95	9.95	9.95	
Audio(12)	17.94	8.97	8.97	
Baseball Digest(12)	14.95	14.95	7.97	10
Basketball Digest(8)	9.95	9.95	7.97	
#Better Hms-Gdns(12)	12.97	6.49	12.97	
#Bicycling(10)	15.97	8.00	12.97	
Black Enterprise(12)	15.00	9.00	7.50	
Bon Appetit(12)	15.00	15.00	15.00	
Boys Life(12)	13.20	13.20	11.97	
Car & Driver(12)	17.00	11.99	11.99	
Cats (12)	17.50	17.50	12.50	
Cat Fancy(12)	17.97	17.97	12.97	
Changing Times(12)	15.00	9.97	9.97	
Child Life:age 6-10(8)	11.95	11.95	9.97	
Childrens Dig:7-11(8)	11.95	11.95	9.97	
Commentary(12)	33.00	33.00	33.00	
#Connoisseur(12)	19.95	10.00	19.95	
Consumers Digest	14.97	14.97	10.97	
Consumers Reports(12)	16.00	16.00	16.00	
#COSMOPOLITAN(12)	**24.97**	**15.00**	**24.97**	
Cruising World(12)	18.00	18.00	14.00	
#Discover(12)	24.00	13.00	14.95	
Dog Fancy(12)	17.97	17.97	12.97	
Downbeat(12)	15.75	15.75	7.95	
Ebony(12)	16.00	14.00	9.97	
The Economist(52)	85.00	51.00	51.00	
Ellery Queen Myst(13)	22.75	19.50	9.97	10
Esquire(12)	17.94	9.95	9.95	
Essence(12)	12.00	9.96	9.00	
Family Circle(17)	14.97	14.97		
Family Computing(12)	19.97	11.97	11.97	
Family Handyman(10)	9.95	9.95	5.95	
Field & Stream(12)	13.94	7.94	7.94	
Fifty Plus(12)	15.00	11.97	11.97	
Financial World(26)	41.95	24.94	18.95	18
Food and Wine(12)	18.00	9.00	15.00	
Football Digest(12)	12.95	12.95	7.97	10
Forbes(28)	42.00	42.00	28.00	
Fortune(26)	42.00	21.00	21.00	
Games Magazine(12)	15.97	15.97	15.97	
Gentlemens Quart.(12)	18.00	13.50		
Glamour(12)	15.00	12.00		
Golf Digest(12)	19.94	11.97	11.97	
Golf Magazine(12)	15.94	8.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Good Housekeeping(12)	14.97	9.97	14.97	
Gourmet(12)	18.00	13.50	15.00	
#Harpers Bazaar(12)	16.97	8.97	16.97	
Harpers Magazine(12)	**18.00**	**9.97**	**9.97**	
Health(12)	22.00	13.32	11.00	
High Fidelity(12)	13.95	6.98	6.98	
Home(12)	15.00	15.00	15.00	
Home Mechanics (12)	11.94	8.97	8.97	
The Homeowner(10)	18.00	13.97	9.00	
Hot Rod(12)	13.94	8.97	8.97	
House and Garden(12)	24.00	18.00		
#House Beautiful(12)	15.97	7.99	15.97	
Humpty Dumpty:4-7(8)	11.95	9.97	9.97	
Jerusalem Post(24)	18.46	18.46	15.97	
Jet(52)	36.00	30.00	26.00	
Ladies Home Jrnl(12)	20.00	15.00	10.00	
#Life(12)	32.50	16.25	25.00	10
M:Civilized Man(12)	24.00	19.95	17.95	10
Mademoiselle(12)	15.00	12.00		
#McCalls(12)	11.95	11.95	11.95	
Metropolitan Home(12)	15.00	7.50	7.50	
Modern Photography(12)	13.98	7.98	6.99	
#Muney(12)	29.95	15.00	19.95	
Mother Jones(12)	18.00	12.00	12.00	
Motor Trend(12)	13.94	7.97	7.97	
MS Magazine(12)	16.00	10.97	10.97	
The Nation (52)	28.00	28.00	9.95	24
Nation's Business(12)	22.00	12.97	12.97	
Natural History(12)	20.00	15.95	15.95	
N.E.Journal of Medicine(52)		60.00		
New Republic (52)	48.00	48.00	28.00	
#New Shelter(9)	10.97	5.50	9.97	
N.Y. Rev.of Books(17)	28.00	28.00	25.95	
New Yorker(52)	32.00	32.00	20.00	
#Newsweek(52)	41.00	21.80	21.80	
Omni(12)	24.00	15.96	15.96	
1001 Home Ideas(12)	22.00	15.97	11.00	
Organic Gardening(12)	12.97	9.97	9.97	
Outdoor Life(12)	13.94	7.97	7.97	
Outside(10)	16.00	12.00	8.97	
Ovation(12)	16.00	8.00	8.00	
PARENTS(12)	**18.00**	**9.00**	**11.95**	
Penthouse(12)	36.00	30.00	30.00	
People(52)	56.50	56.50	28.25	
Personal Computing(12)	18.00	18.00	8.97	9
Petersens Photog(12)	13.94	6.97	6.97	
Playboy(12)	25.00	21.50	21.50	
#Popular Mechanics(12)	13.97	7.00	13.97	
Popular Photogr.(12)	11.97	5.99	5.99	
Popular Science(12)	13.94	7.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Prevention(12)	13.97	7.00	13.97	
Psychology Today(12)	15.99	8.00	12.97	
Reader's Digest(12)	15.41	15.41	15.41	
#Redbook(12)	11.97	6.97	11.97	
Road and Track(12)	17.94	11.99	12.99	
Rolling Stone(26)	19.95	19.95	17.95	
The Runner(12)	16.97	12.97	8.97	
#Runner's World(12)	19.95	10.00	12.97	
Sail(12)	21.75	21.75	21.75	
Saturday Eve.Post(9)	12.97	12.97	12.97	
Savvy(12)	12.00	12.00	6.00	
Science '86(11)	18.00	18.00	13.95	
#Science Digest(12)	13.97	6.99	13.97	
Scientific Amer.(12)	24.00	24.00	24.00	
Self(12)	15.00	12.00	N.A.	
Seventeen(12)	13.95	13.95	13.95	
Shape(12)	20.00	20.00	8.97	6
Ski(8)	11.94	6.97	6.97	
Skiing(7)	9.98	4.99	4.99	7
Skin Diver(12)	13.94	7.97	7.97	
Sport(12)	12.00	7.97	7.97	
Sporting News(24:6 mo)	22.50	11.97	11.97	
#Sports Afield(12)	13.97	6.99	13.97	
#Sports Illustr.(54)	56.50	34.00	29.45	
Stereo Review(12)	9.97	4.99	4.99	
Teen(12)	12.95	7.95	7.95	
Tennis(12)	17.94	8.97	8.97	
#Time(52)	58.25	29.25	28.00	50
#Town & Country(12)	24.00	12.00	24.00	
Travel & Leisure(12)	25.00	12.50	25.00	
TV Guide(52)	31.20	31.20	26.00	
#U.S.News/Wrld.Rep(52)	41.00	20.50	20.50	
Vegetarian Times(12)	19.95	14.95	14.95	
Video(13)	15.00	15.00	7.50	
Video Review(12)	12.00	6.97	6.97	
Village Voice(52)	32.76	32.76	22.00	
Vogue(12)	24.00	21.00		
W Magazine(26)	26.00	23.00	17.95	
Weight Watchers(12)	13.97	11.97	11.97	
Woman's Day(17)	15.13	15.13	15.13	
Women's Sports(12)	12.95	12.95	8.95	
Workbench(6)	6.00	6.00	5.00	
Working Mother(12)	11.95	9.95	9.95	
Working Woman(12)	18.00	12.00	15.00	
World Press Review(12)	16.95	16.95	14.98	
Writer's Dig.(9 iss)	18.00	9.97	9.97	
Yankee (Colonial)(12)	15.00	15.00	12.97	
YM(12)	14.00	10.95	10.95	

#BUSINESS CARD NEEDED FOR OFFICE PRICE

HUNDREDS OF OTHER TITLES AVAILABLE! PLEASE SEND US YOUR REQUESTS!

FMA MAGAZINE PROGRAM
29 Glen Cove Ave., Glen Cove, N.Y. 11542

MAIL MAGAZINES TO:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AFFILIATED HOSPITAL/SCHOOL _____
Required for Educator rates

VISA or M/C No. _____ Exp. Date _____

Prices subject to publishers' changes.

PLEASE SEND THE FOLLOWING MAGAZINES:

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

All subscriptions are for one year unless otherwise noted.
Guarantee: Our prices are the lowest, our service the best.
New Orders: Publishers take from 6 to 12 weeks to start your subscription.
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.

Please make checks payable to: FMA Magazine Program

FLM0186

Deaths

ARBESU, MARIO, Miami; born May 30, 1937; University of Havana and Madrid, 1967; died February 17, 1985.

ARCHER, LESTER, Stuart; born May 9, 1924; George Washington University, 1948; member AMA; died March 15, 1985.

BIANCHI, DOMINICK A., Jacksonville; born March 7, 1909; Hahnemann, 1938; member AMA; died February 17, 1985.

BROWN, ALEXANDER E., Bradenton; born March 18, 1898; University of Minnesota, 1922; member AMA; died May 4, 1985.

BROWN, EDWIN W., West Palm Beach; born March 1, 1917; Duke University, 1941; member AMA; died July 21, 1985.

BURFORD, FRED J., Fort Myers; born September 29, 1930; Emory, 1956; member AMA; died April 30, 1985.

BUTT, ARTHUR J., Pensacola; born March 27, 1914; Tulane, 1939; member AMA; died September 1984.

CABEZAS, JORGE, Miami; born October 12, 1932; School of Medicine, Havana, Cuba, 1962; died October 22, 1984.

CAMPBELL, LINDSEY D., Jacksonville; born July 7, 1921; Bowman Gray, 1956; member AMA; died February 2, 1985.

CHARDKOFF, M. AUSTIN, Tampa; born July 21, 1905; University of Lausanne, 1931; member AMA; died June 2, 1985.

COTTRELL, WILLIAM W., Winter Haven; born May 3, 1931; University of Louisville, 1958; died June 1985.

DAME, GEORGE M., Ocala; born September 21, 1924; Tulane 1954; member AMA; died July 18, 1985.

DEES, JOHN E., Miami; born September 23, 1905; University of Georgia, 1930; member AMA; died January 17, 1985.

DEL CAMPO, CONSTANTINO, Jacksonville; born October 25, 1934; University of Madrid, 1963; died February 18, 1985.

DOBBINS, BURNS A., Fort Lauderdale; born 1915; Temple, 1939; member AMA; died March 12, 1985.

DORMON, GEORGE, Winter Haven; born July 19, 1919; Medical College of Alabama, 1950; member AMA; died February 9, 1985.

EDWARDS, ALBERT T., Miami; born March 23, 1923; Meharry, 1950; member AMA; died June 28, 1985.

FARRIS, WILLIAM B, Bradenton; born January 27, 1907; Vanderbilt University, 1933; died July 28, 1985.

FIX, IVOR, Miami; born June 30, 1924; University of Witwatersrand, 1952; member AMA.

FOLSOM, JOHN H., Orlando; born November 29, 1923; Emory, 1951; member AMA; died February 23, 1985.

FREEMAN, CHARLES A., Ormond Beach; born February 7, 1941; S.U.NY. Downstate, New York, 1966; died February 28, 1985.

GARY, EDWARD T., Miami; born September 30, 1902; George Washington, 1931; died 1977.

GOUWENS, DAVID F., Bradenton; born June 13, 1954; University of Florida College of Medicine, 1979; died April 9, 1985.

GRAY, GENE W., Sarasota; born May 18, 1931; Medical College of Alabama, 1957; died July 15, 1985.

GREENE, JOSEPH, Miami; born June 9, 1909; Western Reserve, 1935.

HERNANDEZ, FRANCISCO A., Miami; born June 11, 1907; Columbia University, 1933; died April 14, 1985.

HEWSON, FRANK M., West Palm Beach; born October 11, 1911; University of Texas, 1937; member AMA; died July 18, 1985.

HICKS, DAVID VERNON, Jacksonville; born April 19, 1937; Liverpool University, 1960; died October 19, 1984.

KATONA, MAYA A., West Palm Beach; born November 29, 1946; Semmelweiss Medical School, 1972; member AMA; died March 17, 1985.

KLASS, ERNA, Miami; born April 13, 1909; Frederick Wilhelm, Germany, 1935; member AMA; died July 17, 1985.

LIBERMAN, M. JACK, Sarasota; born July 27, 1925; Louisana State University, 1952; member AMA; died March 12, 1985.

LITTLE, BOBBIE RAY, Pensacola; born September 20, 1928; University of Mississippi, 1965; died April 17, 1985.

LOVE, CECIL E., Gainesville; born December 7, 1913; Tennessee, 1940; member AMA; died April 11, 1985.

MAGGIORE, MICHAEL J., West Palm Beach; born February 5, 1904; University of Buffalo, 1929; member AMA; died February 10, 1985.

McCORKLE, WALTER W., Vero Beach; born September 16, 1922; Vanderbilt, 1944; member AMA; died April 17, 1985.

McNALLY, JOHN J., Stuart; born April 23, 1923; Long Island College of Medicine, 1948; died April 16, 1985.

MENN, HENRY W., Miami; born April 10, 1938; Georgetown, 1964; died June 25, 1985.

MIMS, LEON H., Miami; born March 22, 1918; Duke University, 1940; member AMA; died April 9, 1985.

MONSERRATE, DOMINGO N., Deerfield Beach; born June 6, 1904; Georgetown University, 1929.

MOON, PLEASANT L., Orlando; born August 27, 1903; Emory, 1931; member AMA; died February 9, 1985.

MORRIS, KENNETH A., Jacksonville; born May 30, 1896; Tulane, 1923; member AMA; died April 22, 1985.

NICKSE, JOSE, Miami; born February 22, 1915; Habana, 1943.

O'MALLEY, MARGARET M., Sarasota; born October 16, 1932; University of Liverpool, 1956; died April 10, 1985.

PARRISH, ALBERT A., Fort Lauderdale; born November 1, 1913; Duke University, 1938; member AMA; died June 26, 1985.

PATTENGALE, NELL T., St. Petersburg; born November 16, 1904; University of Illinois, 1929; member AMA.

PATTERSON, LAWRENCE G., Largo; born January 7, 1904; Ohio State University, 1931; died May 24, 1985.

PICALLO, RICARDO L., Leesburg; born February 26, 1937; School of Medicine, University of Havana, Cuba, 1962; died May 17, 1985.

RODRIGUEZ, OSCAR A., Miami; born February 16, 1919; Havana, 1949; died March 10, 1985.

ROGERS, HUNTER B., Miami; born January 3, 1904; University of Georgia, 1929; member AMA; died November 8, 1984.

ROGERS, H. MILTON, St. Petersburg; born October 27, 1910; University of Pittsburgh, 1935; member AMA; died March 10, 1985.

RUMSEY, RUTH, Miami; born June 6, 1920; Temple University, 1943; member AMA; died June 24, 1984.

SALL, WALTER, Miami; born May 11, 1925; New York University, 1952; member AMA; died July 29, 1985.

SAXON, MICHAEL R., Naples; born Septembe 26, 1910; Northwestern University, 1936; died April 18, 1985.

SCHLAPIK, DANIEL, Miami; born December 27, 1900; Northwestern University, 1925; member AMA; died November 1983.

SCHNEIDER, GARY K., Boca Raton; born February 10, 1953; S.U.N.Y. Downstate Medical Center, 1978; member AMA; died January 12, 1985.

SCHWARTZ, HARRY A., Miami; born May 28, 1906; New York 1929; member AMA.

SHANMUGATHASA, MUTHURKRISHNAPILLAI, Fort Myers; born January 29, 1944; University of Ceylon, 1967; member AMA; died May 4, 1985.

SILBIGER, ALFRED J., Pompano Beach; born July 18, 1906; St. Louis University, 1971.

STEIN, FRANK, Fort Lauderdale; born August 28, 1938; Stritch School of Medicine, Loyola, 1964; member AMA; died August 11, 1985.

TURMAIL, GEORGE A., Stuart; born October 14, 1938; University of Florida, 1965; member AMA; died June 15, 1985.

TYLAR, NORMAN E., Lake Placid; born January 7, 1904; Georgetown University, 1932; died February 3, 1985.

VAN SICKLE, GEORGE R., Tampa; born September 15, 1933; University of Ottowa, 1960; died July 16, 1984.

WAGENER, WILLIAM L., Miami; born June 27, 1914; Hahnemann, 1943; member AMA; died March 15, 1985.

WELEBIR, ANDREW J., Maitland; born July 8, 1914; College of Medical Evangelists, 1939; died January 14, 1985.

WEST, HUGH, Daytona Beach; born March 10, 1899; Emory University, 1923; member AMA; died May 30, 1985.

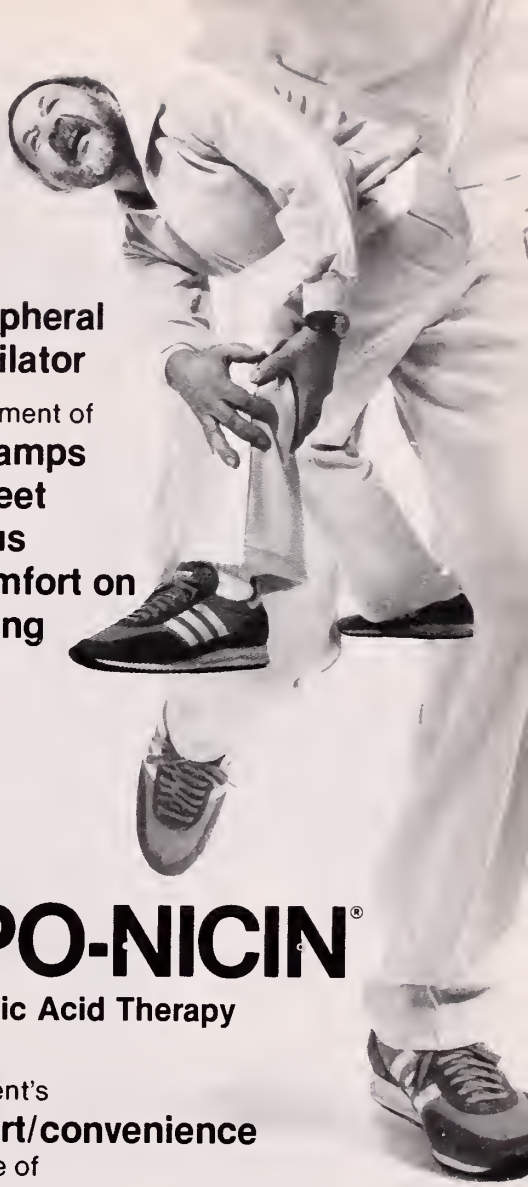
WILSON, LEO H., Sarasota; born January 4, 1924; Duke University, 1947; member AMA; died April 30, 1985.

WOLKOWSKY, MELVIN, Fort Pierce; born December 14, 1920; University of Pennsylvania, 1946; member AMA; died January 1985.

American Diabetes Association

The American Diabetes Association through its service, education and research programs, gives help today and hope for tomorrow to all children and adults with diabetes. YOU can help support these projects by calling your local DIABETES ASSOCIATION, listed in your telephone directory.
CALL TODAY!

Florida Affiliate
(305) 894-6664



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.
Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.,* P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

Physicians' Confidential Assistance

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

YOUR NEW LOW DAILY RATES AT AVIS START AT $33.00



Avis features GM cars. Buick Century.

Your association membership means new, uniform low flat rates at Avis. And there's no charge for mileage. Choose from subcompact through full size 4-door car groups:

DAILY RATE	
SUBCOMPACT (Chevrolet Chevette or similar)	**$33.00**
FULL SIZE 2-DOOR (Buick Century or similar)	**$39.00**

These uniform low flat rates make it easy to know your rate before you go. To reserve a car, call Avis toll free: ***1-800-331-1212***

Be sure to mention your Avis Worldwide Discount number: **A/A616900.**

AVIS ***WE TRY HARDER.®***

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. Flat rates are nondiscountable and are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. An additional charge per day will apply in certain locations including Newark Airport, NJ; LaGuardia Airport, NY; Kennedy Airport, NY; and all Manhattan locations. Check with Avis for the amount. Rates, discounts and additional charges subject to change without notice. Cars must be returned to rental location or higher daily rate and a one-way service fee will apply. Cars and particular car groups subject to availability. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

©1985 Avis Rent A Car System, Inc., Avis®

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

MARCH

Difficult Questions for Pulmonary Medicine, March 1, The Rusty Pelican, Tampa. Contact: David A. Solomon, M.D., 13000 N. 30th Street (111C), Tampa 33612, (813) 972-2000.

Farrior Ear Surgery Course, March 1-6, USF College of Medicine, Tampa. Contact: J.B. Farrior, M.D., (813) 253-0916.

Internal Medicine 1986, March 2-7, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bodes, M.D., P.O. Box 016760, Miami 33101, (305) 547-6063.

Internal Medicine Update, March 2-8, Palace Hotel, Lake Buena Vista. Contact: Barry Sieger, M.D., (305) 841-5144.

Epidemiology and Prevention of Cardiovascular Disease, March 3-5, Good Samaritan Hospital, West Palm Beach. For more info: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Neuroradiology: New Horizons and Current Concepts, March 3-6, Sheraton Bal Harbour, Bal Harbour. Contact: Robert M. Quercer, M.D., P.O. Box 016960, Miami 33101, (305) 547-6716.

Annual Medical Update, March 3-7, Holy Cross Hospital, Ft. Lauderdale. Contact: Jon Fichtelman, M.D., 4725 N. Federal Hwy., Ft. Lauderdale, FL 33308, (305) 492-5728.

Neuroradiology: New Horizons and Current Concepts of Classic Issues, March 3-7, Sheraton Bal Harbour, Miami. Contact: Joyce E. Freeman, P.O. Box 016960, Miami, FL 33101 (305) 549-6894.

Florida Society of Ophthalmology Annual Meeting, March 6-8, Palace Hotel, Lake Buena Vista. For more info: Florida Society of Ophthalmology, 1133 W. Morse Boulevard, #201, Winter Park 32789, (305) 647-8839.

Ophthalmology Talks, March 7-8, Palace Hotel, Lake Buena Vista. Contact: Avery Weiss, M.D., (813) 974-3170.

Professional Liability in the 80's, March 7-9, Saddlebrook Resort, Wesley Chapel, Jeanette Stone, 35 Lakeshore Drive, Birmingham, AL 35219-0088.

Twenty-First Annual Meeting of the American Society of Contemporary Medicine and Surgery, March 9-13, Diplomat Hotel, Hollywood. Contact: John G. Bellows, M.D., 211 E. Chicago Ave., Sute 1044, Chicago, IL 60611, (312) 787-3335.

Ninth Annual Problems in Rheumatology, March 12-15, Don CeSar Beach Resort Hotel, St. Petersburg Beach. Contact: Bernard Germain, M.D., USF College of Medicine, Box 19, Tampa 33612.

Breast Disease Update III, March 12-16, Hilton Hotel, Lake Buena Vista. Contact: Noel Zusmer, M.D., 4300 Alton Road, Miami Beach, FL 33140, (305) 674-2418.

Clinical Management of the Elderly Patient, March 13-15, Palace Hotel, Lake Buena Vista. Contact: The Health and Education Council, 7201 Rossville Blvd., Baltimore, Md., 21237, (301) 686-3610.

Pediatric Urology; for the Urologist, March 14-16, Doral Beach Hotel, Miami Beach. For more info: American Medical International, 6614 Miami Lakes Dr. East, Miami Lakes 33014, (305) 687-1367.

Pediatric Intensive Care, March 17-19, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Brezner, P.O. Box 3166, West Palm Beach 33402, (305) 650-6236.

Winter Symposium, March 17-20, Hyatt Regency Grand Cypress, Orlando, Contact: Gerald Whelan, M.D., P.O. Box 619911, Dallas, TX 75261-9911, (214) 659-0911.

Eighth Annual Family Practice Review, March 17-21, Adam's Mark Caribbean Gulf Resort, Clearwater Beach. Charles Aucremann, M.D., 701 6th Street South, St. Petersburg, FL 33701, (813) 893-6156.

Infectious Disease and Antibiotic Therapy, March 18-22, Palace Hotel, Lake Buena Vista. Contact: Barry Sieger, M.D., (305) 841-5144.

Contemporary Hepatology, March 20, USF, Tampa. Contact: William Boyd, M.D. (813) 972-2000, ext. 425.

Seventeenth Annual Topics in Internal Medicine, March 20-22, Gainesville Hotel, Gainesville. Contact: A. Jay Block, M.D., JHMHC 19-233, Gainesville, FL 32610 (904) 392-3143.

Issues in Perinatal Care — 1986, March 21-22, Halifax Hospital, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Blvd., Daytona Beach, FL (904) 252-4701.

Vascular and Pulmonary Diseases: Diagnosis and Management, March 21-23, Bahia Mar Hotel, Ft. Lauderdale. Contact: Stephen E. Mattingly, (303) 798-9682.

Advances in Diagnostic Imaging, March 22-30, Switzerland, St. Moritz. Contact: Lawrence Miroff, M.D., (813) 974-7267.

Spring 1986 Family Practice Review, March 24-28, Sheraton World, Orlando. Contact: William Stewart, M.D., JHMHC J-233, Gainesville, FL 32610, (904) 392-4321.

1986 Update on Diseases and Imaging, March 31-April 2, Walt Disney World Village Hotel, Lake Buena Vista. Contact: Charleen Krissman, 12901 N. 3oth Street, Tampa, FL 33612, (813) 974-2538.

APRIL

Critical Care Medicine, April 1-5, Hotel Royal Plaza, Lake Buena Vista. Call: Alan Varraux, (305) 841-5144.

Radiology of Hepatobiliary and Pancreatic Disease: Imaging and Intervention, April 1-5, Miami Hyatt Regency, Miami. Contact: Jill Nolden, Division of Diagnostic Radiology, P.O. Box 016960, Miami, 33101, (305) 549-6894.

Issues and Advances in Pediatrics, April 2-4, Sheraton Sand Key Resort, Clearwater Beach. Contact: Lewis A. Barness, M.D., 12901 N. 30th Street, Box 15C2, Tampa, FL 33612-4799.

Fourth Annual Interventional Radiology Seminar, April 2-5, Palace Hotel, Lake Buena Vista. Contact: Martin Selbiger, M.D., (813) 974-2538.

New Approaches to Common Disorders, April 3-5, Adams Mark Resort, Clearwater. Contact: Joel Gleason, M.D., USF College of Medicine, (813) 397-5511.

Regional Cancer Conference, April 8-11, Lake Buena Vista, Lake Buena Vista. Call: Clarence Brown, M.D., (305) 841-5144.

Forty-First Regional Family Practice Weekend, April 11-13, Lincoln Hotel, Tampa. Contact: Robert L. Dawson, M.D., 4057 Carmichael Ave., #229, Jacksonville 32207, (904) 398-5667.

1986 Radiation Therapy Seminar, April 17-19, University Centre Hotel, Gainesville. Contact: Division of Radiation Therapy, JHMHC J-385, Gainesville, 32610.

Clinical Virology Seminars, April 21-23, Holiday Inn Surfside, Clearwater. Contact: Steven Specter, Ph.D., USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 974-2178.

Physiology of Fitness, April 22-26, Sonesta Village Hotel, Orlando. For more info: Alan Varraux, M.D., (305) 841-5144.

MAY

Five-Day Diabetes Management Course, May 12-16, USF College of Medicine, Tampa. Call: Anthony Morrison, (813) 974-4360.

Master Approach to Cardiovascular Problems, May 24-26, Contemporary Hotel, Lake Buena Vista. Contact: Augustin Castellanos, M.D., P.O. Box 016960 (D-39), Miami, FL 33101, (305) 549-7124.

JUNE

Seventh Annual Child Neurology Postgraduate Course, June 9-12, Sonesta Beach Hotel, Key Biscayne. Contact: Oscar Papazian, M.D., 6125, S.W. 31st Street, Miami, FL 33155.

ONGOING

Seminars — Most major ski areas, Club Med, Disney World and other resorts. Topic: Medical/Legal and Financial Management. Accredited. Current Concept Seminars, Inc. (since 1980) 3301 Johnson St., Hollywood, FL 33021 (800) 428-6069. Fee $175.



PREGNANT MOTHERS: PLEASE DON'T SMOKE!

Here are three good reasons to quit smoking now:

1 Smoking retards the growth of your baby.

2 Smoking increases infant mortality.

3 Your family needs a healthy mother.

Don't smoke.
For your baby's sake.
And yours.

AMERICAN CANCER SOCIETY

3rd Annual International Breast Cancer Seminar

Presented in Cooperation with the American Cancer Society

MIAMI

APRIL 3 - 5, 1986



Join 22 leading specialists from all over the world at this important post graduate seminar. They'll be addressing the latest developments in the diagnosis and treatment of all forms of breast disease.

Participants include:

Stephen Carter, M.D.
Bristol-Myers Company, New York
Roy M. Clark, M.B., B.S.
Princess Margaret Hospital, Toronto, Canada
Bernard Fischer, M.D.
University of Pittsburgh, Pittsburgh
Robert L. Goodman, M.D.
The Fox Chase Cancer Center, Philadelphia
John L. Hayward, M.D.
Guy's Hospital, London, England
Craig Henderson, M.D.
Harvard Medical School, Boston
John Peter Minton, M.D., Ph.D.
Ohio State Univ. School of Medicine, Columbus
Jeffrey Schlom, Ph.D.
National Cancer Institute, Bethesda

Approved for 14 hours of Category I credit.

The seminar will be held at the exclusive Mayfair House in the heart of Coconut Grove during the first weekend in sunny, breezy April. Enrollment is limited.

Sponsored by:

AMI and Palmetto General Hospital

For more information on the Third Annual International Breast Cancer Update, mail to: Miami Cancer Conference, Inc.
P.O. Box 56-2110, Miami, FL 33256
(305) 557-1600

Name _____

Address _____

City _____ State _____ Zip _____

Registration Fee $300.

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

MASTER APPROACH TO CARDIOVASCULAR PROBLEMS

Fourteenth Annual Conference

THE CONTEMPORARY RESORT HOTEL
WALT DISNEY WORLD
EPCOT CENTER
Lake Buena Vista, Florida
May 24, 25 & 26, 1986
MEMORIAL DAY WEEKEND

Guest Speakers:

Geoffrey O. Hartzler, M.D.

Present Status of Coronary Angioplasty

J. Willis Hurst, M.D.

What is a Cardiologist in 1986?

Nanette Kass Wenger, M.D.

State of the Art in Cardiac Rehabilitation

UNIVERSITY OF MIAMI FACULTY:

Agustin Castellanos, M.D.
Bernard J. Fogel, M.D.
Stephen M. Mallon, M.D.
Robert J. Myerburg, M.D.
J. Maxwell McKenzie, M.D.

For more information please call (305) 549-7124 or complete coupon and mail to: Y. Barcena, Cardiology (D-39), University of Miami School of Medicine, P.O. Box 016960, Miami, Florida 33101.

Please send me more information regarding
"MASTER APPROACH TO CV PROBLEMS"

Name _____

Phone () _____

Address _____

A Healthy Investment In YOUR Country's Future And YOURS

If you're willing to invest just 27 days a year in your country's future by serving in the Florida Army National Guard, we'll invest in your future by paying you a generous monthly annuity after you retire from the Guard. Payments are based on length of service and rank held at retirement. For more information on the Florida Army National Guard Medical Program please call...

Lieutenant Doug Hernandez

1-800-342-6528

Florida ARMY **National Guard**

GET MORE FOR YOUR ADVERTISING DOLLAR

Purchase A Display Ad in the

Journal of the Florida Medical Association, Inc.

Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203

(904) 356-1571

THE HEALTH CARE WITNESS

What you always wanted to know and couldn't ask.

May 2 and 3, 1986

MARRIOTT'S
ORLANDO WORLD CENTER
Orlando, Florida



This conference is designed to assist physicians and other health care professionals to understand and participate as witnesses in the legal system.

The structure and function of the legal system, role of the witness in relation to the plaintiff's attorney, defense attorney, judge, and jury will be discussed.

Experts from the medical, legal, insurance, court, and academic settings will serve as faculty.

FEATURED SPEAKERS:
Melvin Belli, Esquire
Edward Annis, M.D.

Course Fee: $250.00

For More Information Call: 305-237-6191

Or Write To: Joanne Weisner
Humana Hospital-Lucerne
818 South Main Lane
Orlando, Florida 32801

Sponsored by Lucerne Spinal Injury Center.

Humana Hospital - Lucerne Orlando.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

GENERAL INTERNISTS, THORACIC AND GENERAL SURGERY, DERMATOLOGY, FAMILY PRACTICE, and RADIOLOGY: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

FAMILY PHYSICIAN or general internist to join busy internist in the Florida Keys. Flexible association available. University training preferred. Send CV: R. Carraway, M.D., P.O. Box 2008F, Key West, Florida 33040.

FAMILY PRACTICE opportunity: South Miami area. Board eligible or certified preferred. Excellent pay and working conditions. Affiliated with major medical center. Full or part-time. Respond with C.V. to Box C-1306, P.O. Box 2411, Jacksonville, FL 32203.

FLORIDA MEDICAL DIRECTOR: Full-time salaried position directing a staff consisting of thirty-one (31) full-time physician employees. 180 bed acute care facility, not for profit, located in Bartow, Florida, approximately equal distance from Tampa and Orlando, near Winter Haven and Lakeland. Must be licensed in Florida with a minimum of five (5) years leadership/management experience. Board certified in at least one specialty. Position reports to the Board of Trustees through the Hospital Administrator. Interested parties should send CV to: Hospital Administrator, Polk General Hospital, P.O. Box 816, Bartow, FL 33830.

PRIMARY CARE CENTERS IN FLORIDA, NEW YORK, NEW JERSEY: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full time basis. Positions available in Central and South Florida coastal communities, central and northern New Jersey, and Long Island, New York area. Guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 930 South Harbor City Blvd., Suite 307, Melbourne, FL 32901.

FAMILY PRACTICE: Physician needed in expanding 153 bed hospital to manage ICU, surgical and diverse medical patients in correctional setting. Well equipped facility near Gainesville and UF with competitive salary and good benefits. No O.B. or evening/weekend call. Please call John E. Metheny, M.D., at (904) 496-2222, Ext. 121 or send CV to Medical Director, Reception and Medical Center, P.O. Box 628, Lake Butler, Florida 32054.

FAMILY PRACTICE PHYSICIAN for primary care centers serving migrant and indigent families. Good salary and benefits. Equal opportunity. Send CV to Gil Walter, P.O. Box 1249, Apopka, FL 32703, or call collect (305) 889-8427.

FULLTIME ER positions available in South Central Georgia and North Central Florida. Excellent renumeration. Salary negotiable. For further information call Donna Spina, National Emergency Services, 1-800-645-4848.

TAMPA — Excellent opportunity to become the primary physician of a well established growth oriented family practice in the fastest growing city in the South. Practice benefits include association with a specialty group, computerized management system, x-ray, laboratory, Spirometry, modern offices in pleasant surroundings. We are seeking a Board Certified or Board Eligible Family Practitioner, highly motivated and dedicated to delivery of quality health care. Excellent base salary plus strong incentives based on revenues. We will provide assistance with interview and relocation expense. If you would like to be an important part of our growing team, send your CV to C-1320, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE, INTERNAL MEDICINE, EMERGENCY, M.D.'s needed for rapidly expanding network of ambulatory care centers in the Tampa Bay Area of Florida's Gulf Coast. Paid malpractice/competative salary/flexible work schedule/plus generous incentive packages. Please call or respond with CV to: Kendal B. Stiles, M.D., Medical Director, United Gulf Medical Centers, P.O. Box 31272, St. Petersburg, FL 33732. Ph.: (813) 896-2431.

PRIMARY CARE FACILITY in West Palm Beach seeking P/T physicians for hourly work and full time physicians for future facilities. Send CV to P.O. Box 16474, West Palm Beach, FL 33416.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

FORT LAUDERDALE, MIAMI, PALM BEACH. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, Florida 33317

LOCUM-TENENS: RADIOLOGIST, Board Certified, university trained with academic backgroung, age 47, experienced in most modalities, will consider office and/or hospital-based practice. Please write C-1311, P.O. Box 2411, Jacksonville, FL 32203.

RADIOLOGIST for private outpatient clinic, Coastal Florida City. Approximately 15-20 hours per week. No weekends or nights. Ideal for retiring physician. Send reply to C-1308, Box 2411, Jacksonville, Fl. 32203.

FAMILY PHYSICIAN to join expanding family practice in Jacksonville. Excellent benefits and growth potential. Board certified or eligible preferred. Send CV to Stephen Clark, M.D., 4131 University Blvd. S., Jacksonville, FL 32216.

ORTHOPAEDIC SURGEON: Second orthopaedic surgeon to join a twenty-two member multi-specialty clinic. Board certified or board eligible. Guaranteed salary with incentive bonus. Clinic is located in the heart of the Florida citrus industry and lake country. 1½ hours to either coast! Immediate drawing area — 90,000. For additional information, sent CV to C-1318, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST — Very busy solo general internist on the east coast of Florida looking for an associate. Great opportunity to step into a thriving practice. Call (904) 428-3241 or (904) 427-1301.

UROLOGIST — Central Florida — established BC urologist in solo practice near Orlando needs BC/BE urologist associate. First year salary and productivity bonus leading to early partnership. Send CV and resume of medical/urological experience to: Joe Stansell and Associates, P.O. Drawer W, Sanford, FL 32772.

PEDIATRICIAN — Central Florida — established BC pediatricians in three man practice needs BC/BE pediatrician associate. First year salary and productivity bonus leading to early partnership. Send CV and resume of medical/pediatric experience to: Joe Stansell and Associates, P.O. Drawer W, Sanford, Florida 32772.

MEDICAL EPIDEMIOLOGIST — Newly created position for medical epidemiologist in dynamic urban health department. Successful candidate will develop and implement infectious disease control strategies. Environmental health and health status studies are also a priority. Requires an M.D. or D.O. degree and appropriate academic preparation and experience in epidemiology. Florida medical license required although a public health certificate may be a possibility. Salary competitive and negotiable. Contact: Charles Konigsberg Jr., M.D., M.P.H., Broward County Public Health Unit Director, (305) 467-4270, 201 West Broward Boulevard, Fort Lauderdale, FL 33301.

MEDICAL EXECUTIVE DIRECTOR — Challenging position for a physician to provide medical leadership in dynamic urban health department. Department developing primary care program to interface with categorical public health programs. This individual will be responsible for medical staff, quality assurance and all medical policies in the Department. This is definitely not a low-key retirement position. Requires Florida license to practice medicine and board certification or eligibility in a primary care specialty. Family practice or pediatric background and public health experience highly desirable. This is a State of Florida Selected Professional Service position with generous fringe benefits. Salary competitive and negotiable. Contact: Charles Konigsberg Jr., M.D., M.P.H., Broward County Public Health Unit Director, (305) 467-4270, 201 West Broward Blvd., Fort Lauderdale, FL 33301.

FAMILY PHYSICIAN or general internist to join busy internist in the Florida Keys. Flexible association available. University training preferred. Send CV: R. Carraway, M.D., P.O. Box 2008F, Key West, FL 33040.

S. FLORIDA Cross Cultural Opportunity with Seminole Indian tribe. Challenging full time comprehensive family practice in well equipped offices on 2 rural and one urban reservation. Admit to city hospital, no OB or surgery. Competitive salary, excellent benefits, MP Ins. provided. Florida license required, pilots license helpful. Start March 1. Contact David Hilton, M.D., at (305) 961-1994, M-F, 434-8248 nights and weekends.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T.C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

FLORIDA S.E. COASTAL AREA UNIQUE OPPORTUNITY for someone with Internal Medicine and Emergency Medicine experience. Expanding office based practice-opportunity with equity participation available. Send C.V. in confidence to: SRM & Associates, Inc., 1060 NE 28th Terrace, Pompano Beach, FL 33062.

ESTABLISHED WALK-IN CLINICS — Sarasota Co. Well qualified M.D.'s with primary care background. Excellent working conditions. Pay and incentives according to qualifications. Send CV to T.M. McNaughton, M.D., 540 S. Nokomis Avenue, Venice, FL 33595 or call (813) 484-2167.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4204.

UROLOGIST looking for pleasant associates BC/BE with good patient rapport. Either new to practice or well along in career. Resume and photo. Box 82887, Tampa. 33682-2887.

DUE TO CLINIC EXPANSION, Veterans Administration Outpatient Clinic in West Palm Beach Florida area recruiting for two full-time and one half-time physicians with family practice or internal medicine experience. Boards preferred. Salary commensurate with training and experience. All Federal employment advantages available. VA is an Affirmative Action Employer. Write or call Seymour Chasan, M.D., Chief Medical Officer, VA Outpatient Clinic, 301 Broadway, Riviera Beach, FL, Ph. (305) 845-2800.

VETERANS ADMINISTRATION Outpatient Clinic in West Palm Beach Florida area recruiting for a half-time Urologist. Salary commensurate with training and experience. All Federal employment advantages available. VA is an Affirmative Action Employer. Write or call Seymour Chasan, M.D., Chief Medical Officer, VA Outpatient Clinic, 301 Broadway, Riviera Beach, Florida. Ph. (305) 845-2800.

OB-GYN needed for multi-specialty group; university town in Northwest Tennessee; excellent, fully equipped hospital, JCAH accredited, HCA affiliate. Contact: Joe D. DePew, Administrator, Volunteer General Hospital, P.O. Box 828, Martin, TN, 38237, (901) 587-4261.

TWO POSITIONS AVAILABLE immediately. Excellent opportunity for Family practitioner/Internist. BC/BE in west coast Florida. Immediate appointment with excellent salary, benefits and profit sharing. Reply in confidence to Oneco Medical Center, Attn. B.A. Hooli, P.O. Box 1486, Oneco, FL 34264.

ORLANDO — Physician needed for freestanding ambulatory care center. Competative hourly wage with incentive bonus. Contact Fran Olschner, BVL Family Medical Center, 2531 Boggy Creek Rd., Kissimmee, FL 32743. Phone 305/933-0990 or 305/422-0430.

Situations Wanted

INTERNIST completing sub-specialty fellowship in pulmonary medicine July 1, 1986 seeking academic and clinical practice group for affiliation. CV, recommendations, etc. on request. Please respond to Warren S. Goff, D.O., 21631 Jacksonville Road, Farmington Hills, Mi. 48027, phone 313-474-4414.

PLASTIC AND RECONSTRUCTIVE SURGEON. Recently completed residency, Board Eligible. Seeking any practice situation; solo, group, partnership, etc. Prefer Florida's Southeast Coast, especially Palm Beach County. Immediately available with Florida license. Reply: Alan A. Yurkiewicz, M.D., 32 Hobart Dr., Apt. C4, Newark, Delaware 19713. Phone (302) 737-7071.

NEURORADIOLOGIST: Board Certified, 2 year University Fellowshop, expertise in pediatric and adult CT, angio, myelo and DSA, also excellent skills in general diagnostic as partner for last 2 years in large multispecialty group. Thirty-five years old, married, one child. President, University of Florida graduating class 1978, who wishes to return home. Lawrence H. Schott, M.D., 1818 Lenard St., Wausau, Wisconsin 54401, (715) 675-9900 evenings.

THORACIC-VASCULAR GENERAL SURGEON — 62 years young. Excellent health qualifications. Seeks full or parttime position — ER — Assisting — What do you need? Reply C-1317, P.O. Box 2411, Jacksonville, FL 32203.

PHYSICIAN ASSISTANT: Board certified, 36, 7 years experience in family practice and acute care. Personable, enthusiastic, motivated. Practice management skills. Guaranteed to build practice, increase net income. $175K/yr. ave. gross. Reg. salary pkg. with equity sharing. Prefer coastal S.E. U.S., private sector. Robert White, PA-C, 4214 Redwood Ave., Jacksonville, FL 32207, (904) 731-9079.

RADIOLOGIST, Board Certified. Trained and experienced in most modalities. Available for Locum Tenens. Permanent Position considered. C-1309, P.O. Box 2411, Jacksonville, FL 32203.

PULMONOLOGIST: Will complete fellowship at the University of Kentucky in July of 1986. Looking to locate in Florida. Licensed in Texas and Kentucky. Contact: Jerry Sampson, M.D., 2080 Regency, Lexington, KY 40503, (606) 277-3711.

EXPERIENCED F.P., Board Recertified, Fellow AAFP, Florida licensed, wants association, partnership or a practice in Florida. C-1319, P.O. Box 2411, Jacksonville, FL 32203.

Practices Available

NORTH CENTRAL Florida. University and medical center community. Solo practice. Will phase out if desired. Excellent hospital nearby. C-1305, P.O. Box 2411, Jacksonville, Fl. 32203.

RETIREMENT MINDED OB-GYN in north Florida looking for partner in practice grossing 400,000 t. Partnership immediately with transfer of practice in two years. C-1316, P.O. Box 2411, Jacksonville, FL 32203.

RICHARD LEFFERT, DDS, Associate Executive Real Estate, Inc., specializing in Professional Practice Sales & Marketing. 1715 Stickney Point Rd., Suite A, Sarasota, FL 33581, (813) 924-1231 after hours (813) 922-6161.

ESTABLISHED PREVENTIVE MEDICINE and General Practice in Greater Orlando. $29,000 with equipment; willing to introduce to patients and hospital staff; call evenings (305) 886-5361 or write C-1313, P.O. Box 2411, Jacksonville, FL 32203.

FT. LAUDERDALE — C/L PSYCHIATRY: Busy practice, with potential for expansion. Good location, good reputation, good facilities. Associate, then assume. Terms flexible. CV and reply to C-1315, P.O. Box 2411, Jacksonville, FL 32203.

FOR SALE — Surgical practice and non-invasive lab. Includes office bldg. Adjacent large hospital. Central Florida. Reply C-1317, P.O. Box 2411, Jacksonville, FL 32203.

FLORIDA WEST COAST: Splendidly located, freestanding clinic for family practice or walk-in. Laboratory and x-ray. Rapidly expanding community. Nearby accredited hospital. Annual gross over 400,000.00. C-1321, P.O. Box 2411, Jacksonville, FL 32203.

BEAUTIFUL LAKELAND, FL: Solo family practice and 1,876 square foot office, furnishings and equipment. Four examining rooms, x-ray, lab, EKG, efficiency apartment. Seven hundred bed open staff hospital. Phone 1-813-646-2734.

FAMILY PRACTICE for sale in beautiful Jupiter area. Condo office, equipped, nice. Ideal for F.P. or I.M. Good income. Must retire, health reasons. Two good hospitals, require BE or BC. (305) 747-0279, after 7 p.m. please.

Real Estate

THE OPENING OF OUR new Englewood Community Hospital in Englewood, FL (Sarasota County) provides a unique opportunity for a physician to live in a resort community on the Gulf and grow with an ever busy practice. Contact Dr. E.J. Ryan for a brochure concerning leasing and particulars. Te. (813) 484-4513.

SHARE MEDICAL-SURGICAL office 5½ days, 1500 E. Hillsboro Blvd., Deerfield Bch. FL 33441. 3 exam rooms, lab, and business office. Patrick E. Callaghan, M.D. (305) 428-2420.

SPRING HILL, FL — 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease — owner will finance. (904) 596-4162 weekdays.

HIGHLAND BEACH, Florida (near Boca Raton). East of Intracoastal. On island, deep canal dock, ocean access, walk to private beach. Low crime community. Four bedrooms/split. Built in 1982. Bette Conlon, (305) 391-9400.

DOCTOR MUST SELL new luxury prime condo, Park Plaza, 12th Floor. 3 bedroom, 2 bath. Covered parking, pool, magnificent view St. John's River and downtown Jacksonville. Dock available. Below market. Phone (305) 278-1067.

PHYSICIAN OWNER MUST SELL new fully furnished ocean front condo at Seawatch (Vilano Beach). On ocean, pool, tennis, covered parking. 2 bedroom, 2 bath. Below market. Phone (305) 278-1063.

UNIQUE FRANCHISE available to physicians and dentists only. For information call Bob Richardson (305)977-9322.

Services

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

WE BUY, SELL, LEASE SERVICE new and reconditioned Holter-Stress-Echo-EKG and other medical Electronic Instruments. Contact Ed Bentolila, P.O. Box 8676, Coral Springs, FL f33065, (305) 972-4600.

GREAT SOUTHERN QUAIL hunting at Georgia's fastest-growing quail preserves. Relaxing, enjoyable pastime for busy physicians. Call or write Fred Purvis R.Ph., Mesa Hunt Preserve, Rt. 2 Box 386 A, Adel, Georgia 31620. Tel. (912) 896-2400 or (912) 896-2637 or beeper (912) 333-6001, may leave message.

Equipment

AVAILABLE FOR SALE: Raytheon Model RME-325R X-ray Generator, Raytheon Model TTS 471 Table Tubstand Combination, Machlett DX 42/40 X-ray Tube Unit, Machlett RBL-II Semi Automatic Collimator. Contact John Manry (305) 569-3771 for further information.

SPECTROSCAN UNIT — complete - $50,000. Raytheon Radiographic room, floating table top, 500 MA generator — $15,000. Both used for less than three months. Will consider offers. C-1309, P.O. Box 2411, Jacksonville, FL 32203.

RADIOLOGIST RETIRING: 3 x-ray machines, (2) 20KV, (1) 5KV. (1) tomography unit. Machines are 500MA, 300MA, 125KV. M6 processor and misc. items. Phone: (305) 869-1004.

Meetings

BIOFEEDBACK THERAPIST TRAINING PROGRAM — Six day program (2-3 day weekends) to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. CEU's Available. Jan. 17-19 & Jan. 24-26, or March 1-3 & March 15-17, or May 16-18 & May 30-June 1, or July 11-13 & July 25-27, 1986. For brochure contact: Hartje Stress Clinic, 2429 University Blvd., West., Jacksonville, FL 32217. (904) 737-5821.

1986 CME CRUISE/CONFERENCES ON selected medical topics — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-12 days yearround. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) & AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican, Mediterranean, Alaskan cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

UNIVERSITY OF SOUTH FLORIDA Department of Pediatrics: "Pediatrics for the Practitioner: The Adolescent." The Bay Harbor Inn, Tampa, FL, May 16, 1986. For further information, contact Herbert H. Pomerance, M.D., Program Coordinator, USF Department of Pediatrics, 12901 N. 30th Street, Box 15CE, Tampa, FL 33612-4799.

MAY 1-4, FLORIDA SPEECH, Language, and Hearing Association (FLASHA) Spring Convention, Jacksonville, Florida. Contact: Tim Stavropulos, 5720-1 Atlantic Boulevard, Jacksonville, Fl. 32207. (904) 725-4646. ASHA continuing education credits available.

CONTROVERSIES IN TRAUMA MANAGEMENT, April 18-19, 1986, Miami, Florida. Credit: 10 Ceu's fee: $225.00 physicians, $150.00 paraprofessionals and RN's. Contact: Ms. Kara Atchison, UM/JM Medical Center, P.O. Box 016960 (D-40), Miami, Fl. 33101



Order the free Consumer Information Catalog to be on top of the latest government information on credit, health, home, money matters, and much more. It lists more than 200 booklets, many free. So send for the Catalog now. You'll be head and shoulders above the crowd. Write:

Consumer Information Center
Dept. MR, Pueblo, Colorado 81009

THE APPROPRIATE GIFT FOR AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO:

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

City & State _____

Send the bill for $15.00 (add 7% sales tax if you live in Florida)

Dr. _____

Street _____

City & State _____

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name: _____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

THE PHYSICIAN'S ATVANTAGE

FUTURE transforms the IBM PC AT into a nine-user system to manage your practice.

Now FUTURE Information Systems offers the ATvantage that lets you practice medicine instead of accounting: Computone's powerful combination of Medical Office Management System software and AT expansion hardware. The total system that provides everything you need to automate your office from one of the country's fastest-growing computer dealers.

You can build a single IBM PC AT into a nine-user multi-tasking system with the AT ATvantage board, using any IBM PC, PCjr or inexpensive stand-alone terminals you may already own.



You can reduce paperwork with easy-to-use Medical Office Management System software, designed to let your staff enter or access information and simultaneously perform up to five related functions. Many accounting and management control operations are automatically updated with patient entry and posting.

And you can do it all with FUTURE beside you every step of the way, providing in-house or on-site training, complete hardware and software maintenance and continuous support.

Get the Physician's ATvantage working for you. Contact FUTURE Information Systems today.

Features of the Physician's ATvantage:

- ☐ Instant access to patient balance, insurance submission and insurance payment information
- ☐ Open-item patient accounting
- ☐ Patient statements and "Super-bill"
- ☐ Third-party insurance processing
- ☐ Patient/guarantor relationships
- ☐ Insurance rebilling or write-off
- ☐ Cash flow control
- ☐ Patient history
- ☐ Problem accounts
- ☐ Accounts receivable reductions of 20-50%
- ☐ Patient referrals
- ☐ Appointment scheduling
- ☐ Automatic audit trails
- ☐ Single doctor office, or several
- ☐ Multi-office practices

FUTURE℠ INFORMATION SYSTEMS
A Computone company

MOVING YOU UP IN THE WORLD℠

Pensacola: Cordova Square, 400 Bayou Blvd., Suite 49 • (904) 474-9855
Ft. Walton Beach: 514A Mary Esther Cutoff • (904) 244-8675
Other computer showrooms in a growing number of U.S. cities.

IBM PC, IBM PCjr and IBM PC AT are trademarks of International Business Machines Corp. ATvantage is a trademark of Computone Systems Inc

ADVERTISERS

Air Force Reserves
Recruitment . . . 128

Army Reserves
Recruitment . . . 90

Association for Continuing Education
Meeting . . . 122

Ayerst Laboratories
Inderide LA . . . 122a

Brown Pharmaceutical
Android . . . 87
Lipo-Nicin . . . 141

Certified Medical Representatives, Inc.
Service . . . 91

Curtis 1000 Information Systems
Computers . . . 103

Eli Lilly & Company
Ceclor . . . 106b

E.R. Squibb and Sons, Inc.
Corzide . . . 83

Fair Oaks Hospital
Service . . . 106

Florida Army National Guard
Recruitment . . . 147

Florida Physicians' Insurance
Service . . . 82

Future Information Systems
Service . . . 153

GTE Telenet
Service . . . 117

Humana Hospital-Lucerne
Seminar . . . 147

Info Systems
Computers . . . 122

Marion Laboratories, Inc.
Cardizem . . . 82a

Medical Education Foundation of Miami
Meeting . . . 87

Miami Cancer Conference, Inc.
Seminar . . . 145

Parkway Regional Medical Center
Service . . . 118

Roche Products, Inc.
Dalmane . . . 155

Smith Kline & French Laboratories
Dyazide . . . 98a, 106d

University of Alabama
Service . . . 104

University of Miami
Meeting . . . 146

Upjohn Company
Motrin . . . 106c

Willingway Hospital
Service . . . 127

Wyeth Laboratories
Ativan . . . 91

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

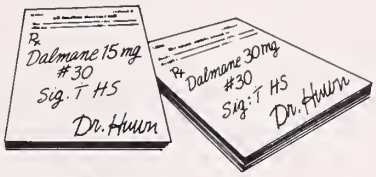
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
flurazepam HCl/Roche Ⓥ
sleep that satisfies

15-mg/30-mg capsules



References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblott DJ, Allen MD, Shoder RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
flurazepam HCl/Roche Ⓥ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side.

DALMANE®

flurazepam HCl/Roche ⓒⅣ

sleep that satisfies



C01183 000
COLL.OF PHYS.OF PHILADELPHIA
LIBRARY
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

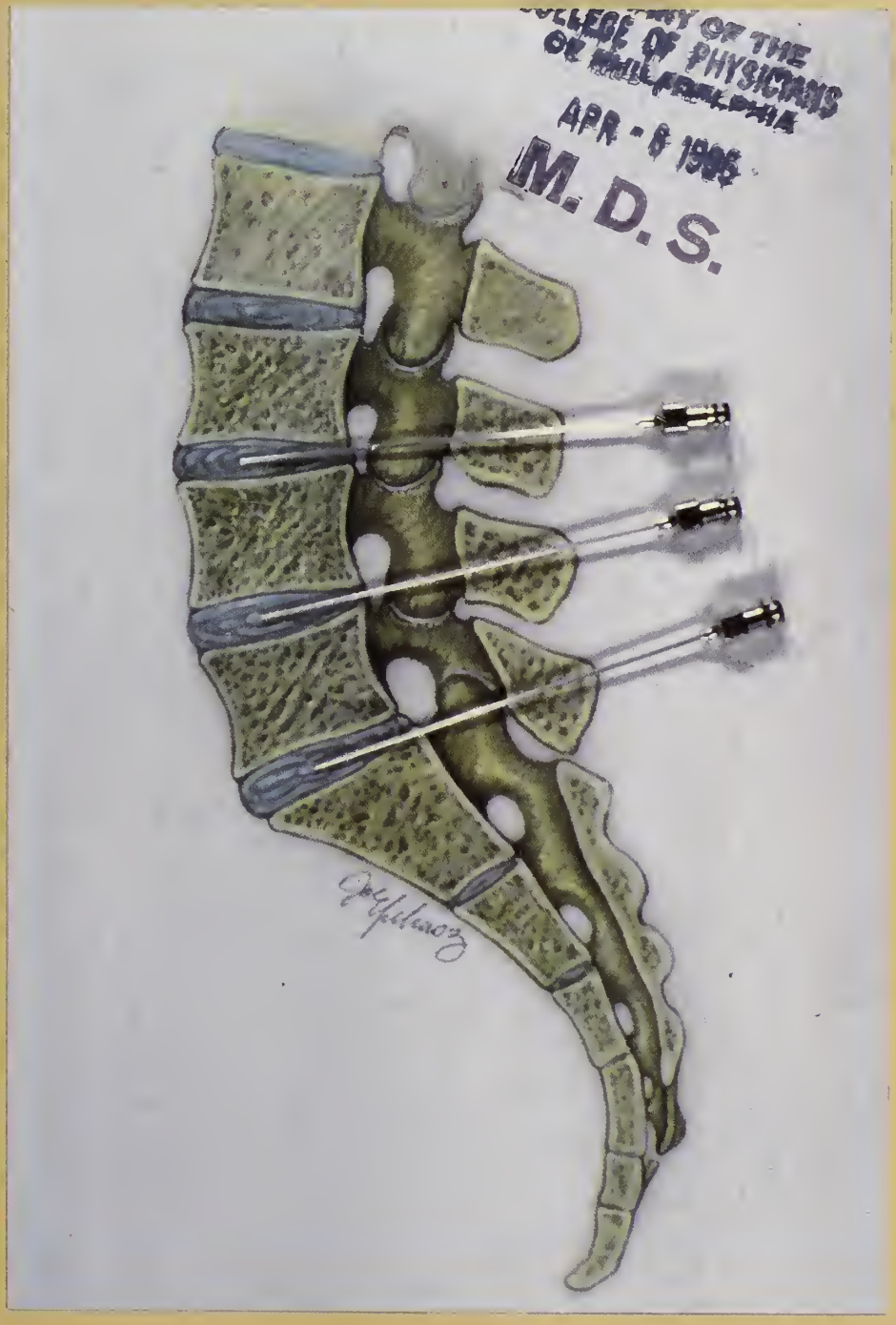
ROCHE®

Copyright © 1985 by Roche Products Inc. All rights reserved.

STACKS

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. March 1986, Vol. 73, No. 3

1986 INTERIM MEETING OF THE HOUSE OF DELEGATES



COLLEGE OF PHYSICIANS
OF PHILADELPHIA
APR - 8 1986
M. D. S.

We are pleased to announce



FLORIDA PHYSICIANS INSURANCE RECIPROCAL

has become

FPIC

FLORIDA PHYSICIANS INSURANCE COMPANY

same address

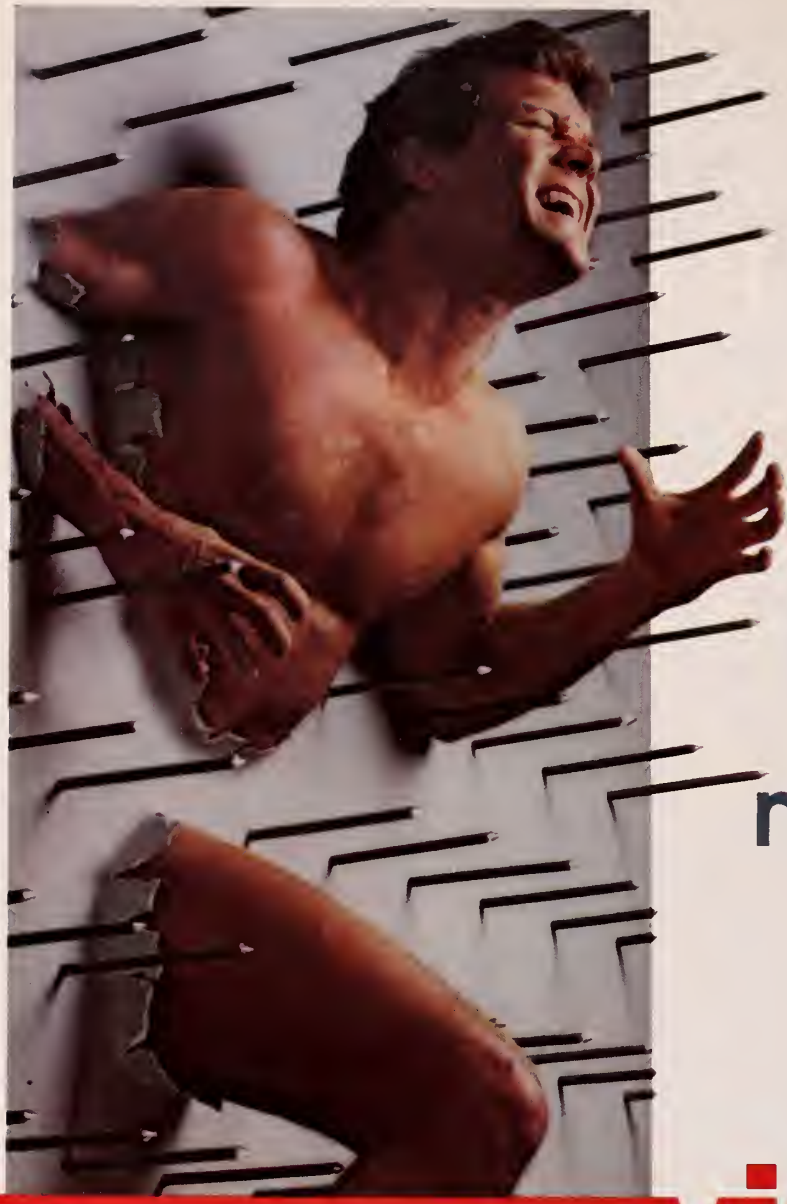
1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

Coming soon from
Burroughs Wellcome Co. Research

WELLBUTRIN®
(Bupropion HCl)



Wellcome



To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
with acetaminophen 500 mg

Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone

WARNINGS

Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics, therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS

Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex. Caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur, they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: (See WARNINGS.)

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.

The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982

knoll® **KNOLL PHARMACEUTICAL COMPANY**
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

5725

February, 1985

10 YEARS

Thank you for your loyal support



DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

SK&F CO.

Motrin® 800 TABLETS mg

ibuprofen



Extra strength
Convenience
Economy

Upjohn

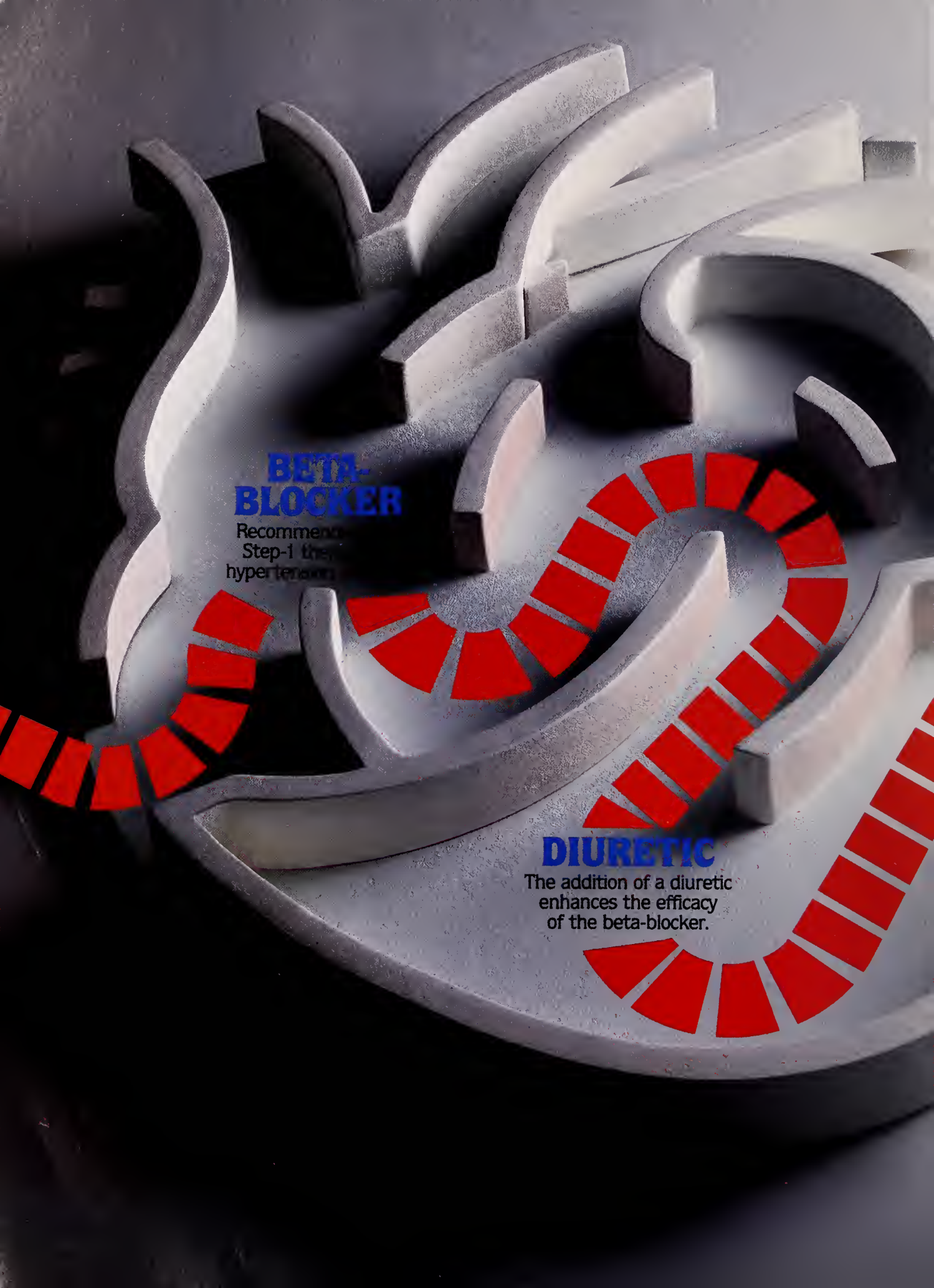
A Century of Caring
1886·1986

©1986 The Upjohn Company

J-6138 January 1986

The Logical Path to Compliance




BETA-
BLOCKER
Recommend
Step-1 the
hyperten
DIURETIC
The addition of a diuretic
enhances the efficacy
of the beta-blocker.

IN HYPERTENSION END POINT:

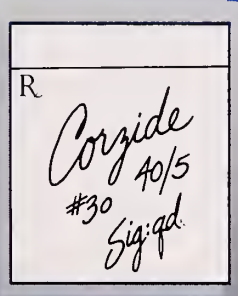
CONTROL, COMPLIANCE, CONVENIENCE

When hypertension control is complicated by the need for a beta-blocker plus a thiazide, CORZIDE® simplifies patient compliance with reliable once-a-day dosing in a single tablet.

CORZIDE®

(nadolol-bendroflumethiazide tablets)

Makes good sense



SQUIBB®

Innovators in cardiovascular medicine

*Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure. The 1984 report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure. Arch Intern Med 144:1045-1057, 1984.

Please see brief summary of prescribing information on following page

CORZIDE®

(nadolol-bendroflumethiazide tablets)

CORZIDE® 40/5
CORZIDE® 80/5
Nadolol-Bendroflumathiazida Tablets

DESCRIPTION: CORZIDE (Nadolol-Bendroflumethiazide Tablets) for oral administration combines two antihypertensive agents: CORGARD® (nadolol), a nonselective beta-adrenergic blocking agent, and NATURETIN® (bendroflumethiazide), a thiazide diuretic-antihypertensive. Formulations: 40 mg and 80 mg nadolol per tablet combined with 5 mg bendroflumethiazide.

CONTRAINDICATIONS: Nadolol — Bronchial asthma, sinus bradycardia and greater than first degree conduction block, cardiogenic shock, and overt cardiac failure (see WARNINGS). **Bandroflumethiazida** — Anuria, and in those with previous hypersensitivity to bendroflumethiazide or other sulfonamide-derived drugs.

WARNINGS: Nadolol — **Cardiac Failura** — Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta-blockade may precipitate more severe failure. Although beta-blockers should be avoided in overt congestive heart failure, if necessary, they can be used with caution in patients with a history of failure who are well compensated, usually with digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle. IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta-blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, digitalize and/or give diuretics, and closely observe response, or discontinue nadolol (gradually, if possible).

Execarbation of Ischamic Haert Diseesa Following Abrupt Withdrawel — Hypersensitivity to catecholamines has been observed in patients withdrawn from beta-blocker therapy, exacerbation of angina and, in some cases, myocardial infarction have occurred after *abrupt* discontinuation of such therapy. When discontinuing chronic use of nadolol, particularly in patients with ischemic heart disease, gradually reduce dosage over a 1- to 2-week period and carefully monitor the patient. Reinstitute nadolol promptly (at least temporarily) and take other measures appropriate for management of unstable angina if angina markedly worsens or acute coronary insufficiency develops. Warn patients not to interrupt or discontinue therapy without physician's advice. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue nadolol therapy abruptly even in patients treated only for hypertension.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA-BLOCKERS. Administer nadolol with caution since it may block bronchodilation produced by endogenous or exogenous catecholamine stimulation of $beta_2$ receptors. **Mejor Surgery** — Because beta blockade impairs the ability of the heart to respond to reflex stimuli and may increase the risks of general anesthesia and surgical procedures, resulting in protracted hypotension or low cardiac output, it has generally been suggested that such therapy should be withdrawn several days prior to surgery. Recognition of the increased sensitivity to catecholamines of patients recently withdrawn from beta-blocker therapy, however, has made this recommendation controversial. If possible, withdraw beta-blockers well before surgery takes place. In emergency surgery, inform the anesthesiologist that the patient is on beta-blocker therapy. Use of beta-receptor agonists such as isoproterenol, dopamine, dobutamine, or levarterenol can reverse the effects of nadolol. Difficulty in restarting and maintaining the heart beat has also been reported with beta-adrenergic receptor blocking agents. **Diabetes and Hypoglycemie** — Beta-adrenergic blockade may prevent the appearance of premonitory signs and symptoms (e.g., tachycardia and blood pressure changes) of acute hypoglycemia. This is especially important with labile diabetics. Beta-blockade also reduces release of insulin in response to hyperglycemia; therefore, it may be necessary to adjust dose of antidiabetic drugs. **Thyrotoxicosis** — Beta-adrenergic blockade may mask certain clinical signs (e.g., tachycardia) of hyperthyroidism. To avoid abrupt withdrawal of beta-adrenergic blockade which might precipitate a thyroid storm, carefully manage patients suspected of developing thyrotoxicosis.

Bendroflumethiazide — Use with caution in severe renal disease. In patients with renal disease, azotemia may be precipitated. With impaired renal function, effects of the drug may be cumulative. Use with caution in impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS: Generel — **Nadolol** — Use with caution in patients with impaired hepatic or renal function (see DOSAGE AND ADMINISTRATION).

Bendroflumethiazide — At appropriate intervals, perform serum electrolytes determination to detect possible electrolyte imbalance warning signs of which are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and G.I. disturbances such as nausea and vomiting. Observe patients for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Drugs such as digitalis may influence serum electrolytes. Hypokalemia may develop, especially with brisk diuresis, in presence of severe cirrhosis. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Response of the heart to toxic effects of digitalis can be exaggerated with hypokalemia. Use potassium supplements such as high potassium foods to avoid or treat hypokalemia. Any chloride deficit is generally mild and usually does not require specific therapy except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than salt administration except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain thiazide-treated patients. Latent diabetes mellitus may become manifest during thiazide therapy. Antihypertensive effects of bendroflumethiazide may be enhanced in the postsympathectomy patient.

Careful reappraisal of therapy and consideration given to withholding or stopping diuretic therapy is necessary if rising nonprotein nitrogen or BUN (indicative of progressive renal impairment) occurs. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Thiazides decrease calcium excretion. Pathologic changes in parathyroid gland with hypercalcemia and hypophosphatemia have been occasionally observed with prolonged therapy. Common complications of hyperparathyroidism have not been seen.

Informetion for Petients — Warn patients, especially those with evidence of coronary artery insufficiency, against interruption or discontinuation of nadolol without physician's advice. Although cardiac failure rarely occurs in properly selected patients, advise patients being treated with beta-adrenergic blocking agents to consult physician at the first sign or symptom of impending failure. Advise patients of proper course if dose inadvertently missed.

Laboratory Tests — Regularly monitor serum and urine electrolyte levels (see WARNINGS, *Bendroflumethiazide,* and PRECAUTIONS, *General, Bendroflumethiazide).*

Drug Intaractions — Nadolol — When administered concurrently the following drugs may interact with beta-adrenergic blocking agents: **Anasthetics, ganeral** — exaggeration of anesthetic-induced hypotension (see WARNINGS, *Nadolol, Major Surgery).* **Antidiabatic drugs (oral agants and insulin)** — hypoglycemia or hyperglycemia, adjust antidiabetic drug dosage accordingly (see WARNINGS, *Nadolol, Diabetes and Hypoglycemia).* **Catecholamina-daplating drugs (a.g., rasarpina)** — additive effect, monitor closely for evidence of hypotension and/or excessive bradycardia.

Bandroflumathiazide — When administered concurrently the following drugs may interact with thiazide diuretics. **Alcohol, barbituratas, or narcotics** — may potentiate orthostatic hypotension. **Antidiabatic drugs (oral agents and insulin)** — thiazide-induced hyperglycemia may require adjustment of antidiabetic drug dosage. **Othar antihypartansiva drugs** — additive or potentiated effect. **Corticostaroids, ACTH** — intensified electrolyte depletion, particularly hypokalemia. **Ganglionic or paripheral adranargic blocking drugs** — potentiated effect. **Preanasthetic and anasthetic agents** — effects may be potentiated; adjust dosage accordingly. **Pressor aminas (e.g., norepinaphrina)** — possible decrease response but not sufficient to preclude their use. **Skalatal muscle ralaxants, nondepolarizing (a.g., tubocurarina)** — possible increased response.

Drug/Laboratory Test Intaractions — Discontinue thiazides before tests for parathyroid function (see PRECAUTIONS, *General, Bendroflumethiazide).*

Carcinogenasis, Mutaganasis, Impairmant of Fartility — Nadolol — In 1 to 2 years oral toxicologic studies in mice, rats, and dogs, nadolol did not produce significant toxic effects. In 2-year oral carcinogenic studies in rats and mice, nadolol did not produce neoplastic, preneoplastic, or nonneoplastic pathologic lesions. **Bendroflumethiazida** — Long-term studies in animals have not been performed.

Pregnancy — Teratogenic Effects — Nadolol — Category C. In animal reproduction studies with nadolol, evidence of embryo- and fetotoxicity was found in rabbits, but not in rats or hamsters, at doses 5 to 10 times greater (on a mg/kg basis) than the maximum indicated human dose, no teratogenic potential was seen in any of these species. There are no well-controlled studies in pregnant women; therefore, use nadolol in pregnant women only if potential benefit justifies potential risk to the fetus. **Bandroflumathiazide** — Category C. Animal reproduction studies have not been conducted. This drug's effect on the fetus when administered to a pregnant woman or its effect on reproductive capacity is not known. Bendroflumethiazide should be given to a pregnant woman only if clearly needed. **Nonteratogenic Effects** — Since thiazides cross the placental barrier and appear in cord blood, weigh anticipated benefit of the drug in pregnant women against possible hazards to the fetus; these hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other reactions which have occurred in adults.

Nursing Mothers — Both nadolol and bendroflumethiazide are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants either discontinue nursing or discontinue therapy, taking into account the importance of CORZIDE (Nadolol-Bendroflumethiazide Tablets) to the mother.

Pediatric Use — Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Nadolol — Most adverse effects have been mild and transient and have rarely required nadolol withdrawal. **Cardiovescular** — Bradycardia with heart rates of less than 60 beats per minute occurs commonly, and heart rates below 40 beats per minute and/or symptomatic bradycardia were seen in about 2 of 100 patients. Symptoms of peripheral vascular insufficiency, usually of the Raynaud type, have occurred in approximately 2 of 100 patients. Cardiac failure, hypotension, and rhythm/conduction disturbances have each occurred in about 1 of 100 patients. Single instances of first degree and third degree heart block have been reported. Intensification of AV block is a known effect of beta-blockers (see also CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS). **Centrel Nervous System** — Dizziness or fatigue reported in approximately 2 of 100 patients; paresthesias, sedation, and change in behavior reported in approximately 6 of 1000 patients. **Respiratory** — Bronchospasm reported in approximately 1 of 1000 patients (see CONTRAINDICATIONS and WARNINGS). **Gastrointestinel** — Nausea, diarrhea, abdominal discomfort, constipation, vomiting, indigestion, anorexia, bloating, and flatulence each reported in 1 to 5 of 1000 patients. **Miscellaneous** — Each of the following reported in 1 to 5 of 1000 patients: rash, pruritus, headache, dry mouth, eyes, or skin, impotence or decreased libido, facial swelling, weight gain, slurred speech; cough; nasal stuffiness; sweating, tinnitus, blurred vision. Although relationship to drug usage is not clear, sleep disturbances have been reported. The oculomucocutaneous syndrome associated with practolol has not been reported with nadolol. The following adverse reactions may also occur. **Centrel Nervous System** — reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability with slightly clouded sensorium, decreased performance on neuropsychometrics. **Gestrointestinel** — mesenteric arterial thrombosis; ischemic colitis. **Hemetologic** — agranulocytosis, thrombocytopenic or nonthrombocytopenic purpura. **Allergic** — fever combined with aching and sore throat; laryngospasm, respiratory distress. **Miscelleneous** — reversible alopecia, Peyronie's disease; erythematous rash; arterial insufficiency.

Bendroflumethiezide — Gastrointestinal System — anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis. **Central Nervous System** — dizziness, vertigo, paresthesia, headache, xanthopsia. **Hemetologic** — leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. **Dermetologic-Hypersensitivity** — purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis). **Cardiovescular** — orthostatic hypotension may occur. **Other** — hyperglycemia, glycosuria, occasional metabolic acidosis in diabetics, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

OVERDOSAGE: Nadolol may cause excessive bradycardia, cardiac failure, hypotension, or bronchospasm if overdosed. Overdosage of thiazides may cause lethargy, which may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function and without evidence of serum electrolyte changes or dehydration. Gastrointestinal irritation and hypermotility may occur. Transitory increase in BUN and serum electrolyte changes may occur, especially in patients with renal impairment.

Treetment — Nadolol can be removed from the general circulation by hemodialysis. In determining duration of corrective therapy, take note of the long duration of the effect of nadolol. In addition to gastric lavage, employ the following measures, as appropriate. **Excessive Bredycardle** — Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **Cardiec Fellure** — Administer a digitalis glycoside and diuretic. It has been reported that glucagon may also be useful in this situation. **Hypotension** — Administer vasopressors, e.g., epinephrine or levarterenol. (There is evidence that epinephrine may be the drug of choice.) **Bronchospasm** — Administer a $beta_2$-stimulating agent and/or a theophylline derivative. **Stupor or Come** — Supportive therapy as warranted. **Gastrointestinal Effects** — Symptomatic treatment as needed. **BUN and/or Serum Electrolyte Abnormelities** — Institute supportive measures as required to maintain hydration, electrolyte balance, respiration, and cardiovascular and renal function.

DOSAGE AND ADMINISTRATION: DOSAGE MUST BE INDIVIDUALIZED. Patients with renal failure require adjustment in dosing interval; see package insert for dosage in these patients.

Consult package insert betore prescribing CORZIDE (Nadolol-Bendroflumethiazide Tablets).

HOW SUPPLIED: Available as scored tablets containing 40 mg nadolol combined with 5 mg bendroflumethiazide and 80 mg nadolol combined with 5 mg bendroflumethiazide in bottles of 100.

© 1986 E. R. Squibb & Sons, Inc., Princeton, NJ 08540
506-504 Issued: February 1986

DON'T GET OUT OF PRACTICE.



Join Shari
PRACTICE MADE PERFECT.

You worked hard to earn the title of doctor, and you've worked even harder to establish your own practice. However, the medical field has never been more competitive than it is today. With HMO's and PPO's it is becoming increasingly difficult to establish and maintain an independent practice and earn the financial as well as the professional rewards you deserve.

That's why we've created Shari Medical Center—because patients, not patience is why you earned your title.

Keep your independence but receive the benefits of a group practice

Shari Medical Centers are made up of a group of qualified physicians joined together for their mutual benefit. In each of the 20 planned Shari locations there will be no less than 30 physicians—10 family doctors to care for the volume of patients needing general treatment and only one physician for each of 20 specialties.

In addition, since this is a group practice, all patients needing special services will be exclusively referred to Shari physicians. For you, that means referrals within Shari Medical Center and the opportunity to be a part of a major practice complete with state-of-the-art equipment. It also means you'll have the advantage of the finest administrative, management, and marketing services that you couldn't possibly afford as a physician in a small practice.

Most importantly, with Shari Medical Center, you will receive an equity position in the center and on-going financial growth for the services you provide. However, you can maintain your private practice while receiving all the benefits of working with a group practice—without getting out of practice waiting for it to happen.

Call Shari at (305)726-6000, outside Broward County, Florida call 1-800-SHARI MD (742-7463)

For a brochure on Shari Medical Center, write to us at: Shari Medical Centers, Corporate Offices, 7310 West McNab Road, Suite 103, Tamarac, Florida 33319.

To find out more, give us a call. We'll be glad to give you more information and show you a Shari Medical Center in operation on a visit to our North Lauderdale location. Then, you can see for yourself, how to get the independence and financial security you want in your practice—made perfect by Shari.

SHARI MEDICAL CENTER

Shari Medical Centers, Corporate Offices, 7310 West McNab Road, Suite 103, Tamarac, Florida 33319

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

MARCH 1986 Vol. 73, No. 3

CONTENTS

SCIENTIFIC ARTICLES

Joseph E. Ortiz, M.D., and Joseph E. Rojas, M.D. **185** Low back pain, sciatica and chemonucleolysis: a community hospital experience

Guy Benrubi, M.D., Robert C. Nuss, M.D., Kay Holmes, M.D., and Nancy Lammert, M.D. **188** Efficacy of cryotherapy in the treatment of human papilloma virus infection of the uterine cervix

John A. Arrington, M.D., F. Reed Murtagh, M.D., Martin L. Silbiger, M.D., Glenn R. Rechtine, M.D., and Steven R. Nokes, M.D. **192** Magnetic resonance imaging of postdiscogram discitis and osteomyelitis in the lumbar spine: case report

SPECIAL ARTICLE

197 1986 Interim Meeting of the House of Delegates

COVER

This month's cover of *The Journal* is a drawing of three needles inside the lower-most lumbar discs. Once the correct placement of the needles is achieved then treatment of the specific herniated disc can be carried out by injection of Chymopapain (Chymodiactin). The drawing was furnished courtesy of Smith Laboratories, manufacturer of Chymodiactin.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.*, [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Forida Medical Association, Inc.

DEPARTMENTS

169 President's Page
1986 Legislative Session holds many challenges

171 Editorials
DRGs and the new patients' bill of rights
R.G. Lacsamana, M.D.
The brown bag syndrome — a deadly epidemic
H. Frank Farmer Jr., M.D., Ph.D.
Jury awards $24 million in Challenger malpractice case
Lee A. Fischer, M.D.

179 Letters and Viewpoints

215 Medical Economics
The elements of power
Jacques R. Caldwell, M.D.

221 Notes & News

223 Encores!

227 Scam of the Month

231 Book Reviews

235 FMA Auxiliary
What is Doctors' Day and why observe it?
Mrs. S. Bruce (Priscilla) Gerber

238 Meetings

240 Classified Advertising

246 Index to Advertisers

246 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Karl Altenberger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.



Health Care At Its Best: Air Force Medicine

Air Force medicine is one of our best benefits, and, with your help, we'll keep it that way. The Air Force needs physicians such as you to become members of our health care team.

Most administrative responsibilities are in the hands of others, giving our physicians the time to give their full attention to the patients' needs. Our hospitals are staffed with dedicated, competent professionals.

You'll find you will have time for your family, and to keep abreast of the latest methods and technologies that you don't have time for now. We also offer unlimited professional development and financial security.

If you're considering a change, consider Air Force medicine. To find out more about Air Force medicine, contact your nearest Air Force recruiter. Experience health care at its best.

Contact: Medical Recruiter, 305/494-2728 or 305/494-2730. An equal opportunity employer.

AIR FORCE

A great way of life.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg Buccal/10 mg Oral/25 mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg





THE HEALTH CARE WITNESS

What you always wanted to know and couldn't ask.

May 2 and 3, 1986
MARRIOTT'S
ORLANDO WORLD CENTER
Orlando, Florida



This conference is designed to assist physicians and other health care professionals to understand and participate as witnesses in the legal system.

The structure and function of the legal system, role of the witness in relation to the plaintiff's attorney, defense attorney, judge, and jury will be discussed.

Experts from the medical, legal, insurance, court, and academic settings will serve as faculty.

FEATURED SPEAKERS:
Melvin Belli, Esquire
Edward Annis, M.D.

Course Fee: $250 for Physicians
$150 for Other Health Care Professionals

For More Information Call: 305-237-6191

Or Write To: Joanne Weisner
Humana Hospital-Lucerne
818 South Main Lane
Orlando, Florida 32801

Sponsored by
Lucerne Spinal Injury Center
Humana Hospital - Lucerne



The appearance of these tablets is a registered trademark of Wyeth Laboratories

DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV)
for (lorazepam)
Anxiety

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

Wyeth Laboratories
Philadelphia, PA 19101

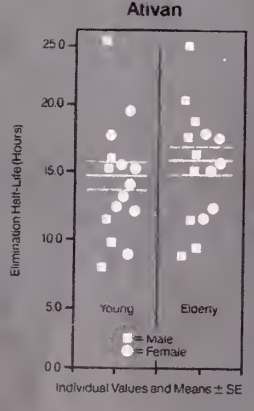
In addition to effective relief of anxiety associated with depressive symptoms...

Only Ativan® (lorazepam) CIV

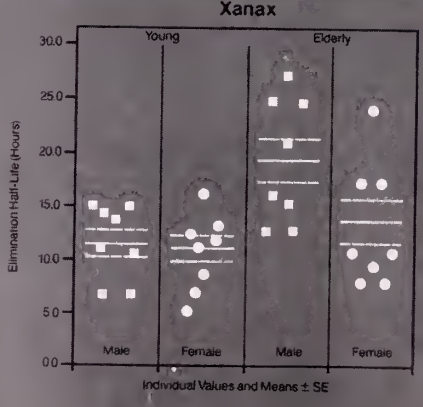
among leading benzodiazepines, has proof that its pharmacokinetics are not significantly altered by age.[1]

With Ativan, elimination half-life was very similar between young and elderly groups tested; differences did not approach statistical significance.[1]

Comparison of elimination half-lives in young and elderly subjects.



Ativan® (lorazepam)[2]
Ativan®, which is *conjugated* rather than oxidized, shows little difference in half-life (t ½) between young and elderly subjects.



Xanax® (alprazolam)[3] CIV
Xanax® requires *oxidative* (P450) metabolism; significant differences in half-life are shown between young and elderly male subjects; half-life is minimally influenced by age in women.

References:
1. Greenblatt DJ: Clinical study, pharmacokinetics and bioavailability in the elderly, Ativan® (lorazepam). Data on file, Wyeth Laboratories.
2. Greenblatt DJ, Allen MD, Locniskar A, et al: Lorazepam kinetics in the elderly. Clin Pharmacol Ther *26*:103, 1979.
3. Greenblatt DJ, Divoll M, Abernethy DR, et al Alprazolam kinetics in the elderly. Arch Gen Psychiatry *40*:287, 1983.

Wyeth Laboratories
Philadelphia, PA 19101

See important information on preceding page.

© 1985, Wyeth Laboratories.

1986 Legislative Session holds many challenges



The next Legislative Session is not going to be an easy one for our profession. Besides our continuing battle to resolve the liability crisis and efforts to repeal mandatory insurance for physicians as a condition of licensure, we have a multiplicity of issues to attend to at the same time, all important and vital to us.

The sunset of all the practice acts occurs this year, and the process of modifying them one way or another is in effect now.

Every one of the health professions from chiropractic to optometry to nursing, physiotherapy, radiological technology, podiatry, etc., may be affected, and we have to monitor every proposal and every modification to be sure none will infringe on the practice of medicine.

Within our own act are serious concerns. Changes in allied health professions are granting hospital privileges to some or diminishing the medical supervision for others. The problem with the foreign medical graduates from unapproved schools; exception for licensure of some considered "special physicians" are only a few of the problems we will have to face.

At the same time, special bills from special groups that come every year over and over again will have to be dealt with as well as new bills from pharmacists, and a wide range of issues and other allied health professions, that will utilize the "sunset" of their acts to modify ours; superimposing their objectives is in the horizon.

The problem of the medically indigent is going to be on the front burner, and we have to strive to find a long term solution, to be realistic and effective, not a bandaid cure that only aggravates the future. We have to make the legislators realize that this is a problem of society and the answers have to be found in society as a whole, and not in a small segment of it, as has been proposed.

The issues are multiple and complex, the solutions are not easy because for everything we want in this democratic system of ours there is a price to pay and either we pay that price or we have a temporary change that in the long range is not effective.

We are going to need your help, the help of every physician in the state in the next Legislative Session. We need your participation in the Assembly for Liability Reform on April 21st but we need your help throughout the entire Session. We need you to be available to come to Tallahassee and testify before the committies that will be debating the health issues important to us and to the people of Florida. We need you to visit your legislators, call them, write them personal letters when a crucial vote is coming, we have to influence it one way or another, we need you actively involved because you are the voice of the roots of Florida Medicine and you can be the most influential force that we can use to be effective.

Resolution of the liability crisis in our state remains the FMA's top legislative priority. We all have to realize that this is a battle that has no cartel; is constant, intense, and pressure has to be kept on during the whole process if we are going to emerge triumphant and with benefit to physicians and the public.

The enemy is powerful, wealthy, intelligent and skillful, and we cannot underestimate them; they know all the avenues, they know how to apply pressure because their richness depends on maintaining the status quo and they will be persistent and

ruthless if necessary. We have to adopt this attitude and realize we cannot continue being the nice doctors who smile at controversy and avoid confrontations; victory must be achieved.

Morally we are right. The people of Florida will be the ones that ultimately will pay the consequences of a liability system which is wrong and damaging to the interest of the whole population. We have to make the decision to change it and this legislative session can do it.

Balance must be obtained before chaos is rampant and doctors will not be able to practice medicine, and the multitude of small businesses and enterprises have to raise their prices to astronomical levels or close their doors.

Let us all join together and give a good fight this year so that all affected by the liability crisis can have some breathing room until further change can be made to remove the threat to our professional life.



DRGs and the new patients' bill of rights

One major concern by physicians when Medicare inaugurated a prospective payment system through DRGs was the possibility that some patients may get short-changed by the new rules. The economic incentives imposed by the new system, it was pointed out, would force hospitals to pressure physicians into discharging their Medicare patients as soon as possible. Shorter stays would mean more profits for the hospitals, while longer stays may mean drastic losses and even bankruptcy. Indeed, two years after the advent of DRGs, hospitals across the country were showing a hefty 14% profit margin. At the same time, questions were being raised on whether the quality of care of the elderly has been impaired, particularly in view of the Heinz report documenting incidents of premature discharges, coupled with the inability of most of these patients to complain about their care.

It is too early at this time to draw any conclusion on whether there has been any systematic increase in the number of hospital premature discharges. But the perception that this is even happening has led a number of consumer groups, led by the AARP, to pressure the government to tack on more safeguards for Medicare patients who need to be hospitalized. As an outgrowth of these pressures, HHS Secretary Otis R. Bowen on February 24 announced that his department was drafting a bill of rights for Medicare patients, specifying that hospital discharges should be based on medical reasons, not when DRG payments run out for their particular illnesses. In addition, Medicare patients not satisfied with their hospital care will now have access to a toll-free number to each state PRO for a speedy resolution of their complaints.

It seems ironic at first that Secretary Bowen would issue such a bill of rights, particularly since it is unthinkable that physicians, who are perceived as advocates for their patients, would discharge their patients prematurely even when their medical conditions do not justify so. Furthermore, the current malpractice atmosphere would appear to militate against this. But the damning Heinz report to the Senate, even while its conclusions are still tentative, had shown that some patients were indeed being shafted. It is easy to see why this may have happened. Prodded by economic motives and a slight touch of paranoia, hospitals across the country have waged a relentless campaign to their medical staffs to think, live, and breathe by DRGs, and this is reflected in the unflagging zeal and occasional overkill of utilization review committees in flagging Medicare patients as early as three days after admission, in the ubiquitous appearance of reminders on patients' charts of when they can be discharged and whether some tests can be carried out on an outpatient basis, and in the practice of what has been described as "creative" diagnosis and "fictional" chartkeeping. Some hospitals have gone as far as offering incentives, bonuses, or rebates to their staff members who cost the hospitals much less than DRG payments for their Medicare patients. Under these pressures, a few physicians may have succumbed to the temptation to discharge some patients against their better judgements.

Under the new bill of rights drafted by the HHS, the burden now falls on hospitals to assure that Medicare patients get appropriate medical care without putting undue pressures on physicians to discharge their patients earlier than they should. Discharges done by physicians will not be subject to appeal; those initiated by hospitals, on the other hand, can be appealed to the State PRO, which in turn is expected to make a decision within three days after receiving an appeal. A prompt decision will obviate

possible financial entanglements for both patients and hospitals. Tilting the balance by giving Medicare patients better access to an appeals process may curb the overzealousness of some hospitals and prohibit them from adversely influencing the discharges of their Medicare patients. Some physicians, because of financial motives through arrangements with the hospitals, may still discharge their patients quicker, but the state PROs are now under increased pressures to monitor practices of physicians which may constitute substandard medical care. The checks and balances afforded by the patients' bill of rights will make it easier to eliminate abuses and harder to beat the system.

The effectiveness of the new bill of rights will depend on how well the state PROs are able to solve the problems brought to them by patients. A number of these organizations have been criticized for being understaffed and underfunded; in addition, questions have been raised about the ability of many PRO staff members to do effective peer review. Unless these shortcomings are corrected, there is little hope that Medicare patients with legitimate complaints about their hospital care can get justice even with the new and reinforced safeguards.

Physicians should stand squarely behind their patients, particularly on matters designed to protect them from uncaring and incompetent physicians and from hospitals where the primary concern is the bottom line. The proferred bill of rights from the HHS is a big step in that direction. We all need to support it.

R. G. Lacsamana, M.D.
Editor

The brown bag syndrome — a deadly epidemic

Throughout recorded history the practice of medicine has been described as an art and a science. Whether the art or the science has been the predominant force has often depended on the individual physician and the state of medicine at that particular time. In recent years various observers have decried the domination of medicine by the scientific approach and the decline of the art of medicine. This domination of medicine by science has been pointed to as one of the negative aspects of the current practice of medicine and some physicians have called for a return to the art of medicine which by implication places a great deal of blame for the problems of modern medicine on the scientific approach. I have also felt that technology, machines and statistics have sometimes placed caring, compassion and clinical skills on the back shelf in our armamentarium. It is easy to assume this position. However, a recent incident has caused me to rethink this philosophy and has led me to conclude that the art of medicine may also be a culprit and carry with it some degree of blame for the troubles which we physicians find ourselves in at the present time.

In order to pursue this thought, it becomes necessary to define and arrive at a common ground on what is the art of something as opposed to the science of something. Most of us have little difficulty in understanding what constitutes a scientific approach. It is generally understood that science incorporates those things related to a branch of knowledge requiring careful and systematic study, observations and tests to arrive at a conclusion. In medicine, this has become the accepted approach with various tests being used to support and come to the diagnosis. The scientific method has definite rules and procedures which enable us to proceed from step to step with proper documentation. As such, it is relatively inflexible and because of this has been criticized. Those who argue for a more flexible approach have pointed out that individual variations of the "human factor" are not accounted for in a purely scientific approach and more emphasis should be on the art of medicine. The definition of the art of medicine is more difficult to clearly delineate. Art is usually defined as a skill or a knack. As such, art applied to medicine means the knack of practicing medicine in a skillful manner. What does that mean? It means that the physician is able to practice medicine and be recognized by his patients and colleagues as a "good physician."

Obviously, the art of medicine and the science of medicine are usually practiced by all of us as we attempt to balance the scientific approach and the art of medicine in a skillful manner. Those physicians who criticize their colleagues for using a large number of tests to treat patients often point with pride to themselves for practicing more of the art of medicine. From this point on it gets difficult to more precisely define the art of medicine. Is it the ability to perceive what a patient is trying to say but is unable to articulate his problem? Is it the knack to ascertain when a patient with a physical complaint has an emotional basis for the complaint without running a myriad of tests? Is it the ability to make a patient feel satisfied when he leaves your office and to think that he is going to get well? I suppose that the logical answer is all of these things and more. The use of the art of medicine does not come without its dangers. If the art of medicine includes the pleasing of patients, and it does, then the consequences of that pleasing

will have to be weighed against the possible adverse effects. This is where most physicians have failed to follow the decision making process through to the possible conclusions. If the art of medicine is invoked in the treatment of a patient then the final results must be taken into account, not just the immediate gratification or satisfaction of that particular patient.

This easily forgotten truth was recently brought to my attention by a problem that exists in our society, a problem that is iatrogenically induced and violates a basic tenet of the practice of medicine — do no harm. This came about as several of my colleagues became concerned about the plight of many of the senior citizens of our area because of the cost of the drugs. With the price of drugs rapidly rising and some citizens being forced to choose between drugs and food, we wanted to find a way that would provide needy patients with a method to obtain medications at a reduced cost. In an effort to find a way to do this, we approached a local agency, the Council on Aging, to see if it would help coordinate efforts between pharmacies, patients and insurance companies to help achieve our purpose. To all of our surprises, the director of the Council informed us that while obtaining the medications was beyond the financial ability of many senior citizens, it was not the major problem. When we heard this we were very perplexed. What could be a more serious problem? The director quickly told us. "The problem is too much medicine." She then went on to explain how many hundreds of senior citizens often came to the Council with their medications in a brown bag. She explained that the average person would have 15 to 20 different drugs and some as many as 50. The bottles were so numerous that the patients found it more convenient to carry them in a grocery shopping bag. Many of the drugs were out-of-date or prescribed by several doctors. However, a great many prescriptions were written by the same physicians over a relatively short period of time and contained various classes of drugs such as antihistamines, cough suppressants, expectorants, anti-inflammatory agents, anti-ulcer medications, antispasmodics, anticonstipation, antiarrhythmias, etc., etc. It was to the point that many of the patients seemed to be in a state of stupor and in a perpetual drug-induced trance. Because of what was happening, the Council organized "brown bag parties" and invited senior citizens to bring all their medications. A pharmacist came and tried to help sort all the drugs, many of which potentiated each other or worked diametrically opposed to other drugs which the patient was taking. A great deal of fault must be assumed by the patients who go from physician to physician or keep drugs for years and take them intermittently. However, that does not exonerate the medical profession as many of the drugs were prescribed by each patient's individual physician over a short period of time.

How did this happen? Are we, the medical profession, poisoning America and for what reason? Certainly, we are not deliberately doing this and most physicians, like me, do not even think of this as a problem. Apparently, however, it is a tremendous problem with sociological as well as medical ramifications which may have drastic consequences. It comes about for many of us as we try to practice the art of medicine. How many of us have been faced with a patient with a complaint for which we cannot find a basis which would warrant a medicinal approach and yet leaves our office with medications? It can be found in every field from the patient with a sore throat to the one with the headache, low back pain or other entities. Are we practicing the art of medicine because that patient leaves with a drug and feels satisfied, or should we inform the patient that drugs are not indicated and other modalities such as dietary change for bowel complaints, warm soaks for tired muscles or saline gargles for sore throats are more appropriate? If a patient does not get the medications which he may obviously want and leaves dissatisfied, does that constitute practicing poorly the art of medicine?

I think most physicians know that vitamin B12 is indicated for pernicious anemia and has no physiological basis for "pepping" a patient up. Yet there are thousands of patients who apparently receive B12 shots because they "feel better." I have had physicians tell me that they see no harm in administering B12 shots. The implied conclusion is that the patient is happy and this is all part of the art of medicine. Unfortunately, what is left out of this thinking is that an individual action can never be divorced from the consequences of that action to the group of which the individual belongs. In this case, the group is a combination of the practice of medicine and society as a whole. The point of all of this is that if we practice the art of medicine and neglect the scientific and sociological consequences, we have violated a basic premise of doing no harm and have instead done a great deal of harm and put ourselves in a position where we have become the antagonists toward our patients. We are no longer the patients' advocates or protectors. We have become the enemy.

To ignore this problem will bring wrath on our heads and continue to help create a class of drugged citizenry stumbling about in confusion. Like the scientific approach, the art of medicine carries with it a commitment of responsibility to society and to medicine as a whole and not just to the immediate gratification or satisfaction of a particular patient in an instance of time.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor
New Smyrna Beach

Jury awards $24 million in Challenger malpractice case

Cocoa Beach, FL (AP) — A jury today awarded the family of S.S. Challenger $24 million in a malpractice case filed after Mr. Challenger died suddenly following coronary by-pass surgery in 1986. The surgical team, headed by Dr. U.S. Nasa of Houston, Texas, and the receiver of the bankrupt Thomas-Morgan Company that manufactured the faulty graft will each pay 50% of the award.

Mr. Challenger, at the time of his death, was a 59-year-old male with progressive angina. He was admitted for elective coronary by-pass surgery. Because it was not an emergency, the surgery date was to be scheduled after some further tests were run. The surgical team headed by Dr. Nasa was considered one of the best in the country. They were supported by manufacturers of various equipment including a new synthetic vein graft, recently approved for use by the FDA, to be used to by-pass the blocked coronary arteries. The graft had been fairly well received, although there had been a few problems during the clinical trials. On the day of surgery, unbeknown to the surgeons, a group of technicians involved with the development of the by-pass graft was meeting at the Thomas-Morgan plant in Utah to consider new reports of failure of the grafts 12 hours after surgery, information that the surgeons received only later.

The surgery began somewhat later than originally planned because the surgical team decided to take another look at the patient's catheterization pictures before proceeding. During the staff conference many of the younger members of the team voiced strong concern about using the new graft for Mr. Challenger's particular condition, but they were overruled by Dr. Nasa and the three senior surgeons. The surgery went as planned and the patient was sent to the cardiovascular intensive care unit in stable condition. Ten hours post-op Mr. Challenger suffered a cardiac arrest, and despite heroic measures, including rushing him back to the OR, he died. At autopsy, two of the synthetic grafts were found to be torn along small seams in the material, the same problem that had occurred in a few other cases. The FDA subsequently banned the use of the Thomas-Morgan graft.

During the trial experts on both sides debated whether the surgery should have been performed in the first place and whether the synthetic vein grafts should have been used at all. The most damaging testimony seemed to be the fact that the senior surgeons, including Dr. Nasa himself, ignored the warnings of the younger team members. It was also argued that the manufacturer knew that its grafts were prone to failure although the company argued that the failure of the seams was a "maloccurence, one of those things that happen occasionally." Since the filing of the lawsuit, the Thomas-Mogan Company has gone bankrupt and its assets are in receivership. Dr. Nasa's surgical team was unable to obtain professional liability insurance and most of the surgeons have since joined other groups. Attorneys for the Challenger family hailed the verdict as a victory for all those who have been and will be injured at the hands of "incompetent butchers" and "greedy businessmen who try to raise their profit by cutting corners."

The explosion of the space shuttle Challenger, January 28, 1986, was a tragedy which profoundly affected every American. Everyone knows that accidents can and do happen, but we never expected one to happen to our space program. We were all shocked that such a thing could happen to the United States. Now, as the initial shock and period of mourning fade into the past, and as more and more information becomes available, we are asking hard questions. Was the space shuttle disaster truly an accident, was it only an unexpected result, one of the risks one takes in any endeavor, or was it out and out negligence? No matter what the answer, if the space shuttle accident had been a medical tragedy the outcome would be a gigantic lawsuit with plenty of adverse publicity and a recitation of the trial lawyers standard party line, "malpractice is caused by doctors who commit malpractice."

Will the space shuttle program and NASA suffer the same fate as my hypothetical malpracatice case? I doubt it. Because NASA and the shuttle program are government programs which have won the hearts of Americans for decades, the outcome will probably be forgiveness and renewed determination to forge ahead. Unlike a medical malpractice case, if the families of the astronauts tried to recover money by filing a wrongful death lawsuit, they would be hard pressed to get anywhere. It seems that six of the astronauts aboard the shuttle were government employees and the amount of money to which their families are entitled is limited by law; they could not sue even if they had wanted to. The family of the one civilian on board theoretically could sue, but so far it has not.

Medicine is not an exact science any more than space travel, yet doctors are being dragged into court not only for actual negligence but also for anything that goes wrong, even if the maloccurence is a common and even frequent result. All it takes is a lawyer willing to take the case, a $100 filing fee, and someone to state that the defendent doctor "failed to live up to the standard of care;" check the legal journal's classified ads for the name and address of someone in your community. Society sanctions a double standard by admitting that in some areas it is A-OK to make a mistake, even one with tragic

results, and even when that mistake was at least an "unexpected result" and at worst actual negligence. The space shuttle program, with the blessing of society, seems sure to survive the Challenger tragedy. I hope the practice of medicine survives the liability crisis, but unless changes are forthcoming and soon, I have my doubts.

Lee A Fischer, M.D.
Associate Editor
West Palm Beach



Our Comprehensive Cancer Sp



The UAB Comprehensive Cancer Center was selected in 1973 as one of the first 11 comprehensive cancer centers funded by the National Cancer Institute. Today, the center is staffed by more than 135 member physicians and devotes more than $21 million annually to treatment and research of cancer.

The work of the UAB Comprehensive Cancer Center is carried on through five clinical divisions—Hematology/Oncology, Gynecologic Oncology, Radiation Oncology, Pediatric Hematology/Oncology, and Surgica Oncology. Special services offered by the cer ter include: • Estrogen and progesterone hor mone assays for breast cancer. • Lymphocyte markers for patients with leukemias and lym phomas. • Immunogenetics screening (HLA typing). • The use of implantable drug infusion pump for continuous chemotherapy. • Isolated limb perfusion for melanomas of the extremity. • Interstitial irradiation for selected solid tumors. • Laser Bronchoscopy. • Combined modality treatment for lung cancer.

The Cancer Center carries out clinical



cialists are sitting on your desk.

esearch in the diagnosis and therapy of vari-
ous anemias, immune cytopenias and coagula-
ion disorders. In addition to chemotherapy,
he Center is studying the use of hyperther-
nia, monoclonal antibodies and the pharma-
cology of anticancer drugs.

The Comprehensive Cancer Center
s one of 60 departments, divisions and cen-
ers of the University of Alabama Medical
Center accessible to you through Medical
nformation Service via Telephone.

The Center welcomes physician inquiries.
To speak with a physician, to consult about a patient, to refer a patient, or to request a patient transfer via the Critical Care Transport Service, telephone by using the MIST number.

Consult With A Specialist, Call

MIST: **1 800 292-6508**
IN ALABAMA
1 800 452-9860
OUTSIDE ALABAMA

UAB The University of Alabama at Birmingham

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network
GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC.
P.O. BOX 2411, JACKSONVILLE, FL 32203
TELEPHONE 904/356-1571

Mandatory malpractice insurance and potential problems of our non-compliance

I received a call today from a fellow physician in Dade County who wanted to make some inquiries about the 1985 legislation that will compel all physicians in Florida to purchase professional liability insurance on January 1, 1987. He wanted to know how the law will be enforced, and he asked me what I thought the Board of Medical Examiners would do if a large group of physicians made a public announcement of their intent to defy the law and not purchase insurance.

Florida utilizes a biennial registration for all physicians and the next renewal period will be January 1, 1988. The legislation requiring all practicing physicians to have insurance will have been in effect for ten months when the next biennial registration notices are mailed out to physicians in early October 1987. It is now tentatively planned that the mailing from DPR will include two affadavits that all physicians must sign: one attesting to the fact that he has performed the statutorily prescribed number of hours of continuing medical education, and another attesting that he possesses the statutorily determined amount of professional liability insurance.

All physicians must sign those affidavits and it is anticipated that DPR will perform random audits on physicians to determine if they have complied. If a physician fails to sign those affidavits, indicating that he has not fulfilled the requirements, or if he signed the affadavits and is then discovered by the audit to not be in compliance, he may be disciplined by DPR and the Board. The physician who attests to his participation in CME courses and possession of insurance and is then found through the random audit to not be in compliance may also be charged with perjury, a third degree felony.

The Board of Medical Examiners is governed by rules and regulations and in fact its very existence is determined by a group of regulations known as the medical practice act, Florida Statutes, chapter 458. The Board must follow these laws and it often requires legal assistance from an assistant attorney general assigned to the board to help it act legally and properly. Boards or individual board members who participate in any activity which violates the law or board rules have left themselves open to lawsuits which may have to be defended at personal expense. The state will only defend suits against regulatory boards and members of those boards as long as they act legally and in good faith.

What I envision taking place, if the requirement for insurance remains as part of the law, is that most physicians will purchase the prescribed amount of insurance rather than risk being in violation of the law. Those who are discovered to not be in compliance, either through the routine random audits or by complaints filed by hospitals, clinics, plaintiff attorneys and other sources, will be investigated by members of the DPR staff. If the investigation demonstrates that they have no insurance and are practicing in violation of the law, their investigative file will be referred to the Probable Cause Panel of the Board of Medical Examiners, which will have no choice but to find probable cause that the individual has violated the law. The Board of Medical Examiners will ultimately mete out some form of discipline, most likely a fine and letter of reprimand, which becomes a permanent blemish on the physician's professional record.

The act of violating the law by practicing without insurance, in my mind, will have accomplished little or nothing except to create financial and personal distress for the physician involved. If he continues to practice without insurance after being disciplined

once, he will face further discipline, including the possible suspension of his medical license.

My colleague then asked me what would happen if he and a large group of other physicians announced that they would cease practicing on January 1, 1988 rather than be required to purchase insurance or violate the law by practicing without insurance. I am uncertain whether they would have to actually relinquish their license or merely just refrain from practicing during the period they possessed no insurance. The Board of Medical Examiners would have to seek an opinion from the Attorney General's office on this point.

I could not think of any benefit that would occur from such an action anyway. Only the Legislature can reverse previous legislation, unless a suit was filed and a judge ruled that the original legislation was unconstitutional. Such legal remedies should have been initiated already rather than waiting until 1987 when the law is scheduled to take effect. If the action by my colleague and other physicians takes place in January 1987, there is no hope of legislative relief until the 1987 Legislative session begins on April 1, 1987, leaving them with a three month period to cease the practice of medicine or to practice without insurance and be in contempt of the law.

The public relations aspect of such a collective action is certainly difficult to assess at this point, but I believe it will be a very dangerous undertaking for the physicians involved. Some legislators may become outraged at such a public display of illegal activity, and I do not believe that the public will happily support such a collective strike by physicians now, when the public's feelings toward the medical profession are ambiguous, to say the least. I would dare to say that most people believe that physicians should maintain professional liability insurance. Most physicians would maintain insurance, and the relatively few who stopped practicing or went without insurance would only hurt themselves economically, as their patients would have relatively easy access to many other physicians in the community.

I personally have very mixed emotions about professional liability insurance. On one hand, I have insurance and I strongly believe that all physicians should protect themselves and their patients from injuries that may result from negligience. I have had relatives and friends injured in automobile accidents by drivers of vehicles who had no insurance, and it is quite painful to be injured through the negligience of another person and have no legal recourse to collect payment for medical care and other damages. I can be criticized by some physicians for not completely understanding their plight, since I am at relatively low risk as a dermatologist and pay relatively little for my protection.

On the other hand, I am disturbed that the Legislature ordered the medical profession to maintain professional liability insurance when no other profession or occupational group has been ordered to do so. In Massachusetts, the state legislature has ordered all physicians in that state to accept insurance assignment on all patients as a condition of maintaining a medical license, fixing fees at an arbitrary and preposterously low level, while malpractice insurance premiums and the other costs of maintaining a practice continue to rise. The harrassment of the medical profession by state and federal bureaucrats knows no limit and doctors are quickly running out of legal remedies to protect themselves from their ultimate destruction as a profession.

Many physicians will be marching to the Capitol in Tallahassee on April 21, while others will march to their county courthouse or some other local municipal building to demonstrate solidarity and their displeasure with the law that requires them to have insurance. They also want to demonstrate their frustration and anxiety with the current problems facing the malpractice insurance industry and the medical profession.

Because we are professionals, independent, educated, and intelligent individuals, we must each make up our own mind about this issue. We must each decide whether we feel that physicians should have professional liability insurance, and whether they should be required to do so by the state government, individual hospitals, or even by our own professional organizations, such as state or county medical associations.

We must each decide whether we want to participate in the march to the Capitol on April 21, but we must remember that if the legislature fails in the upcoming session to rescind or alter the existing legislation that requires each of us to have minimum professional liability coverage by January 1, 1987, then failure to have insurance will mean disciplinary action by DPR and the Board of Medical Examiners: a painful and expensive experience for any physician. We each must decide now and act quickly and appropriately.

Richard J. Feinstein, M.D.
Miami

The time for reason, courage, and action is now

Professional liability insurance is written to cover damages occurring because of malpractice by the professions of law, medicine, accounting, architecture and others. Today it either does not exist

(for plaintiff attorneys) or is so expensive many cannot or will not pay the price (Litt, *Miami Herald*, January, 1, 1986). When increasing numbers of physicians refused to charge their patients more money to pay for the spiraling premiums, the Florida State Legislature passed Bill Number 1352 mandating such insurance would be a requirement for licensure in 1987 (Granat, *Miami Herald*, December 24, 1985). Will mandatory insurance for all the professions and businesses be the next step?

The professions are now joined by businesses and banks with soaring liability premiums for members of Boards of Directors (300%, *Miami Review*, December 2, 1985 to 5,000% *Personal Communication*) in the past year. Product liability problems have bankrupted large corporations (A.H. Robbins, Co., Manville, etc.). Pharmaceutical companies have stopped producing vaccines that save thousands of lives because of rare serious reactions and subsequent legal entanglements that threaten their existence. Corporations, large and small, cannot risk the exposure required to produce new and innovative products. Many small businesses are simply closing because they cannot afford liability premiums. Transit casualty insurance companies are filing for bankruptcy leaving hundreds of city-owned transit lines and private bus companies without coverage. Insurance has become the second highest expense, exceeded only by labor in that and other industries. Even municipalities are "going bare," being unable to properly budget and tax for liability insurance.

Each day the newspaper informs us of additional businesses unable to cope with liability payments: bowling alleys, roofers, nursing homes, gasoline stations, shopping centers, financial advisors, etc. are all victims of the "tort system." Surely, where liability is concerned, this system has failed the people of this nation.

The medical profession has been brought to its knees. Bewilderment with incredulous huge court settlements is demoralizing and destroying the most sophisticated and efficient medical system on earth. A breakdown in health care delivery is imminent: 30% of the obstetricians will no longer deliver babies in the State of Florida. In answer to legislative limits passed last Spring, the Florida Supreme Court this month is considering contingency fee guidelines recommended by the Florida Bar. Should not that court also consider the constitutionality of the oppressive mandatory liability insurance law passed by the legislature that singles out one group of citizens?

Recognizing that accidents do not occur on purpose, liability insurance began as a good idea to reward the injured and at the same time protect those who inadvertently caused the injury. However, money and greed have corrupted that concept so that we now have an avalanche of liability premiums which are crushing our population while rewarding a select few with the equivalent of a winning lottery ticket.

Staggering liability insurance rates combined with decreased coverage and increased deductibility, have resulted in a frightened citizenry, threatened with catastrophe by any accidental occurrence. We are a nation held hostage by the fear of liability settlements which can destroy a lifetime of building and saving and trying. Individuals and companies, alike, have paid huge sums for liability insurance to protect themselves but like all blackmail, this protection money has never been enough and increases each year. The insurance industry is claiming a 5.5 billion loss for 1985, 45% more than 1984's record (*Business Week*, January 13, 1986). Ron Krauss, spokesman for the insurance trade group in New York, stated, "We have a liability system out of control. . ." (*Miami Herald*, January 7, 1986).

Doctors blame greedy lawyers, contingency fees, and the tort system. Lawyers blame doctors for poor patient care and insurance companies for increasing premiums to cover losses from bad investments. Insurance companies blame the courts for awarding huge settlements and both plaintiff and defense attorneys for prolonging the legal process in order to increase their fees. Business blames the whole system for interfering with the ability to produce products and generally accomplish the business of the nation economically and effectively (*Wall Street Journal*, December 3, 1985).

People do not know who to blame but do know there is plenty of blame to go around. They also know products cost too much, medical care costs too much and legal fees are too high. They know this because they work to earn the money that pays for this unjust system. They see expenses for liability insurance going up in geometric progression and they want a solution now. Lawyers, doctors, businessmen and insurance companies have all failed completely to stop or even slow this crisis. It is clearly the responsibility of the legislature of the State of Florida to do so in the next session or in a special-called early session. The time is now for that elected body to recognize this crisis exists and it is real. It is time for them to rise up with resolute courage and reason what is best for the people of this state. If the Legislature does not perform this duty to the electorate, then the members will be held responsible, and rightly so, for perpetuating a crisis which is injurious to every person in the State of Florida.

Banning G. Lary, M.D.
Miami

What has the AMA done for me lately?

As we outline out budgets for 1986, physicians are not surprised to see that costs continue to climb. Among our expenses are our dues bills for membership in our professional organizations — county, state, specialty societies and the AMA — and the total figure is significant. Because we typically have more frequent contact with our local medical societies it is sometimes harder for physicians to feel "in touch" with our national association — the AMA. As a long-term member of the Florida delegation to the AMA House of Delegates, I have made it my business to be in touch with the AMA. What I see and hear impresses me, and it should do the same for every physician in Florida and throughout the country. I am often asked by some of my colleagues, "What has the AMA done for me lately?" Simply stated, the answer is "Plenty!" But the question deserves an in-depth answer and I would like to take this opportunity to provide it.

AMA membership provides both tangible and intangible benefits. Chief among them is representation of the medical profession. The importance of this activity is reflected in the AMA budget — in 1985, 28% of the Association's budget was allocated to its primary mission, representation. This activity is so broad in scope that I would like to give you some specifics.

Last year, the AMA engaged in over 1,200 Congressional visits, 260 White House contacts and 1,700 contacts with federal agencies. These contacts represented physicians in the areas of professional liability, attempts to limit physicians' fees, mandatory Medicare assignment and extension of DRGs to physician services, among a myriad of others.

Hundreds of bills on health-related issues are introduced into Congress each year. The AMA Council on Legislation, assisted by AMA staff, reviews each of these as well as other proposed legislation. The AMA then formulates a position and engages in the appropriate follow-up which may include making legislative contacts, coordinating member activities for pro or con action, providing verbal or written testimony, and lobbying.

In a related note, AMA lobbyists are among the most highly respected in Washington. Sometimes months before a bill is put together, congressional committee members or their staffs will contact AMA's lobbyists on an issue under consideration, to find out the AMA's viewpoint. Legislators also frequently ask AMA lobbyists how the physician back home feel about a certain issue and the AMA Washington Office maintains a non-negotiable policy in this sensitive area — honesty. I quote John Zapp, the Director of the Washington Office: "We let the member of Congress know not only the AMA's position but also the sentiment in his or her district, where the physicians may be evenly divided or perhaps even opposed to the AMA position. That is why it is so important for us to work closely with the state medical associations and keep up with what is happening there."

The AMA's Office of the General Counsel engages in a different kind of representation on behalf of physicians — litigation. Within the last year, the AMA filed suit against the Secretary of HHS to block implementation of the Medicare fee freeze; filed an *amicus* brief in the U.S. Supreme Court in an antitrust action in which the AMA urges full recognition by the Court of the importance and procompetitive nature of professional ethics and quality of care self-regulation; pursued in a Federal Court of Appeals and in the U.S. Supreme Court AMA's opposition to intrusive federal intervention in the treatment decisions regarding severely impaired infants (the *Baby Doe* litigation); filed suit with the Massachusetts Medical Society challenging the recently enacted Massachusetts law which, in effect, mandates assignment under Medicare as a condition of licensure; continued its active defense of three antitrust suits filed by groups of chiropractors which challenge AMA's support of the ethical principle that physicians should refer patients only to competent medical practitioners who employ scientifically accepted methods or treatment; and so on. AMA may not win all its battles but there are more victories than losses, and in any case, they keep fighting when the issue warrants it.

On another "front," the AMA has made the professional liability crisis a top priority — a position we understand all too well here in Florida. The Association created a Special Task Force on Professional Liability and Insurance which outlined 18 initiatives in four areas of concern — education and community action, legislative and judicial reform, defense coordination for physicians and their attorneys, and risk control and quality review. Many of these recommendations have already been implemented. For example, the Task Force prepared and distributed throughout the country a detailed response to allegations of the Association of Trial Lawyers of America that "there is no medical malpractice crisis;" commissioned studies to accurately document the cost to society of the professional liability crisis as well as the savings from tort reform; established a permanent coordination mechanism with the major specialty societies to build a unified assault on the problem; and established a toll-free number at AMA to answer professional liability questions from physicians and their attorneys. Of course, the crowning achievement this past year in this area was the introduction in Congress of federal legislation drafted by the AMA to obtain prompt state action on tort reform. These efforts will continue through 1986 and beyond until we physicians can provide quality medical care without

fear of undue liability exposure. The Task Force has established as a major activity for 1986, an examination of alternatives to the tort system for resolution of professional liability claims.

All this activity in the area of representation does not mean that the scientific side of our profession is neglected — far from it. The AMA also allocated 26% of its budget to providing scientific information and another 8% to maintaining educational standards for physicians. Again, I would like to give you some specifics.

Through its Diagnostic and Therapeutic Technology Assessment (DATTA) project, the AMA studies new medical technologies and procedures to determine their effectiveness and suitability for clinical uses. These evaluations are conducted by panels of physicians expert in their fields and offer indispensable guidance for medical researchers, practicing physicians and national health policymakers.

The AMA Council of Scientific Affairs advises the Association, the profession, government and other health organizations on various aspects of medical science. Among its activities, the Council evaluates and proposes scientific initiatives that might be undertaken by the AMA unilaterally or with other organizations, and presents its findings to the AMA House of Delegates for further action.

The AMA disseminates scientific and health-related information to both the profession and the public through a number of means. Scientific information is provided to physicians via *JAMA* — which enjoys international prestige and is now published in seven languages, nine specialty journals, the AMA library — which is the second largest medical library in the United States and maintains on-line access to more than 300 computerized data bases, and the computerized GTE Medical Information Network (MINET) — developed by AMA and GTE Telenet to give physicians and hospitals up-to-the-minute information on drugs, diseases, medical procedures and clinical literature, as well as provide interactive teaching modules and a daily medical news service via computer terminal. AMA also publishes *AMA News*, a weekly newspaper reporting on the socio-economic events affecting medicine, and numerous booklets and references on scientific and socio-economic subjects. To help us help our patients, AMA publishes books, pamphlets and posters on a wide variety of subjects. Patient Medication Instruction (PMI) sheets are also available for us to give to our patients to reduce the risk of improper drug use and aid in patient compliance. The AMA also publishes a seven-volume Home Health Library, which includes such books as "Back Care," "Heart Care" and "Woman Care."

These last few points have moved into the area of the tangible benefits of AMA membership, and I would like to share with you a summary of these that has been provided by AMA at my request for use in this article. An AMA member who takes advantage of the following benefits — some of which are provided at no cost as an automatic benefit of membership — would save $523.75 per year over the cost to a nonmember: *JAMA*; one specialty journal; *American Medical News*; purchase of the book, "Current Procedural Terminology (CPT)"; one Video Clinic course; one Market Area Profile (MAP) — a recently developed service which provides detailed demographic, physician an hospital data on a specific location to assist the physician in selecting a practice site or adapting an existing practice to changing conditions; one AMA Library computerized document search; use of the AMA Placement Service; subscription to MINET; enrollment in one Practice Management workshop; rental of one Practice Management vidoecassette; one Physician Recognition Award; and use of a Hertz rental car. This does not even include the savings to members who enroll in any of the AMA-sponsored insurance programs or the AMA Members Retirement Plan.

From a purely financial perspective, AMA membership is a good deal. For slightly more than a dollar a day, you receive a vast array of benefits and services. In fact, the AMA's advertising and investment income enables it to provide members $2.00 in service for every $1.00 in dues (dues make up less than half of the AMA's annual budget). None of us could buy such valuable assistance or influence at so little cost through any other means.

But the fact is that looking at AMA membership from a financial perspective alone is foolish. It is impossible to put a price tag on the only national organization that speaks for our profession as a whole. What is it worth to have a forum of medicine in which we physicians raise and argue issues, reach a consensus and formulate policy? What is it worth to have that policy translated into practical action in Congress, in the courts, and in helping our patients lead healthier lives?

I will not try to tell you that the AMA is perfect. Like any organization it has its weaknesses. But I ask you to name one other national organization that works for physicians in so many areas, on such a broad scale, and does it so effectively. Frankly, I cannot think of any that even comes close.

What has the AMA done for me? It is out there working for me. It is a staff in Chicago and in Washington. But, most important, it is our organization. It is doctors working for doctors — and our patients.

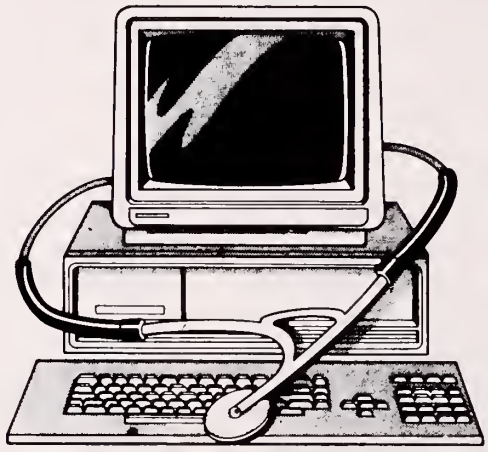
Eugene G. Peek Jr., M.D.
Ocala

Reprinted with permission from *The Bulletin of the Marion County Medical Society*, Vol. VIII, No. 1, January 1986, page 1.

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
MARCH 1986, Vol. 73, No. 3

Low back pain, sciatica and chemonucleolysis: a community hospital experience

Joseph E. Ortiz, M.D. and Joseph E. Rojas, M.D.

ABSTRACT: Chemonucleolysis provides a safe and effective therapeutic method for the patient with a herniated lumbar disc who has not responded to conservative management. With proper patient selection and precise surgical technique, results can equal those of laminectomy.

This study consists of 197 patients who underwent intradiscal therapy with chymopapain. All were candidates for laminectomy and disc excision. Eighty-seven percent had excellent or good results without any major complications. Even though it seems simple, chemonucleolysis requires close attention to diagnostic and technical details.

The Authors
JOSEPH E. ORTIZ, M.D.
JOSEPH E. ROJAS, M.D.
Drs. Ortiz and Rojas are Board Certified Orthopedic Surgeons practicing at Jess Parrish Memorial Hospital, Titusville, and members of the Chemonucleolysis Resource Center Network.

Sciatica is a symptom that can be present in various disease conditions of which herniated nucleus pulposus is but one. Low back pain is second only to the common cold as a reason to seek medical attention. Its economic impact has been calculated as close to $25 billion yearly in the United States alone.

Prior to late 1982 the only treatment available in the United States for a herniated disc that did not respond to conservative management was laminotomy and discectomy; 200,000 surgical procedures were being done annually with varied results. However, in late 1982 the Food and Drug Administration approved chymopapain for the treatment of herniated lumbar discs, thus providing another therapeutic alternative to open surgery. This study presents and discusses our experience in a Florida community hospital in the treatment of herniated discs with chymopapain.

Review of literature • Chymopapain is one of the proteolytic enzymes contained in crude "papain," a mixture derived from papaya latex.[1,2]

Thomas first described the effects of papain in hyaline cartilage.[3] Hirsch in 1959 suggested the possibility of injecting a proteolytic enzyme into a protruded nucleus pulposus to relieve clinical symptoms.[4] After considerable laboratory and clinical research, Smith in 1964 reported his experiences with chymopapain in the clinical setting.[5,6] Subsequently a multitude of studies both pro and con have been published on the subject of chemonucleolysis.[7-10]

Diagnostic criteria • We strictly adhered to McCulloch's well known rule of five in establishing our diagnosis. Briefly these are:

1. Leg pain (including buttock) as the dominant

symptom affecting one leg and following typical nerve distribution.

2. Paresthesias or numbness following a dermatomal pattern.

3. Straight leg raising limited at least by 50% and/or aggravated by dorsiflexion of the ankle and/or positive bowstring test.

4. Presence of two of the following signs: reflex changes, weakness, wasting or sensory loss.

5. Positive radiological investigation such as a CT scan or myelogram.

Materials and methods • From February 1983 until June 1985, 197 patients underwent chemonucleolysis, 107 males and 90 females ranging in age from 16 to 68 years with a mean of 42. One hundred thirty four were from Puerto Rico, 62 from the United States and one from West Germany. Each patient fulfilled all five diagnostic criteria. None had undergone a previous surgical procedure anywhere in the spine. Seventy five were injected in the L5/S1 disc, 96 in the L4/5 disc, five in the L3/4 disc, one in the L2/3 disc, and 20 had injections at two levels. In the two level injections, 15 were at L4/5/1 and five at L3/4/5. Duration of symptoms ranged from six weeks to nine years with a mean of 22 months. Follow up was from three to 21 months. Procedures were performed by either of us with assistance of the other.

Surgical technique • The enzyme preparation manufactured by Smith Laboratories (Chymodiactin) was the drug used on all patients. All patients received the following as anaphylactic shock prophylaxis: Cimetidine 300 mg po q 6h, Diphenhydramine 50 mg po q 6h. Once under anesthesia the patient was placed in the left lateral decubitus position. The lateral approach was used in introducing an 18 gauge needle into the involved interspace using biplanar image intensification. A discogram (discontinued after July 84) was then performed using Reno-M-60. Permanent films were taken and after a 15-minute waiting period a test dose (0.3 cc) of the enzyme was injected. If no allergic reaction was detected after 15 minutes 1.5 cc of Chymodiactin were injected slowly. The patient remained one hour in the recovery room under close observation then was returned to his room.

Postinjection management • Patients were allowed out of bed ad lib within the limits of pain from the first postoperative day. During the first three weeks further increase in activities was encouraged and return to office type work was allowed by the end of this period. After six weeks a physical therapy program consisting of flexion exercises was started progressing to a Nautilus rehabilitation program.

Rating method • All patients were available for follow-up examinations on several occasions to both of us and were evaluated using the following criteria:

EXCELLENT: Asympotomatic, negative examination, no restrictions in any activities.

GOOD: Occasional back discomfort requiring non-narcotic analgesics and muscle relaxants, no restrictions.

FAIR: Improved but requiring schedule III or IV analgesics to relieve the worst pain; restricted in occupation but not in activities of daily living.

POOR: No improvement whatsoever.

Results • One hundred thirty-eight (70%) patients had an excellent result, 35 (17%) good result, seven (4%) fair result and 17 (9%) poor result. The mean age was 42 years. Postinjection spasms developed in 80 (41%). So far there have been no recurrences.

L5/S1 level • Seventy-five injections were done at the L5/1 level. Fifty-three patients had an excellent result, 13 good result, three fair result, and six poor result. Postinjection spasms developed in 18.

L4/5 level • Ninety-six injections were done at the L4/5 level. Sixty-eight patients had an excellent result, 17 good result, two fair result, and nine poor result. Postinjection spasms developed in 39.

Two levels • Twenty injections were done at two levels, 15 at the L4/5/1 levels and five at the L3/4/5 levels. Fifteen patients had an excellent result, five good result, and none either a fair or poor result. Postinjection spasms developed in 12.

Thirty patients were younger than 30 years and 28 of them had an excellent result, two good result, none fair or poor result. In contrast, 143 patients were over 30 and of those 91 had an excellent result, 30 good result, six fair result, and 16 poor result.

Ninety-one patients were under workmen's compensation. Of these 58 had an excellent result, 17 good result, four fair result, and 12 poor result.

Complications • None of the patients had any anaphylactic shock type allergic reaction. One had hives 15 minutes after the injection. There were no neurological complications immediate or delayed. There was one case of aseptic discitis. The only other complication encountered was postinjection spasms which at times were severe and on the average increased the hospital stay by one day. The incidence of spasms was highest in patients undergoing two level injections.

Failures • We considered treatment a failure when after 90 days there was no improvement whatsoever in symptomatology and 17 patients had to be included

in this category. In two of them the involved levels were already degenerated preinjection. One later underwent surgery and the surgeon reported finding spinal stenosis. The other patient refused surgery. Of the remaining 15 patients, four had surgery, 11 refused. Operative findings in two of the four were herniation of the disc consisting of mostly collagenous material with foraminal stenosis in one case. The operative findings and results on one patient are unknown. Of the four two had an excellent result, one good result, and one in unknown.

None of the patients classified as a fair result has undergone a surgical procedure.

Discussion • Our data supports the contention by several other authors that chemonucleolysis is a safe, effective method of treating sciatica due to a herniated nucleus pulposus in the lumbar spine, unresponsive to conservative treatment.[7-9] The principal reason for our success rate is meticulous patient selection. Only those who presented with all five criteria set forth by McCulloch were chosen for treatment. There is no doubt that if the same selection criteria were utilized, similar results could be reproduced.

We believe that the safety of this method is intimately related to a precise surgical technique. Lately there have been reports of catastrophic neurological complications which we believe relate to improper needle placement technique more than anything else. Our technique (submitted for publication), although very simple, allows us to take into account different sizes of different patients and assures accurate and uncomplicated placement of the needle.

Analysis of failures reveals that although these patients did fulfill the diagnostic criteria there were certain anatomical abnormalities which could have prevented a good result. We believe that the presence of segmental spinal instability, moderate to severe disc degeneration, lateral recess and/or foraminal narrowing should be considered a relative contraindication to chemonucleolysis. It is of prime importance that the radiological investigation include a CT scan of the highest quality and resolution so that only those cases in which root compression is by herniated disc and nothing else can be selected for chymopapain injection.

The postinjection paraspinal muscle spasms remain a frequent although temporary complication which does not respond readily to medication. We found a significant increase in the incidence of spasms in the two level injections. We believe that the sudden decompression of the nuclear contents by chymopapain renders the injected segment(s) acutely unstable. The spasms are an attempt by the spine to stabilize itself. Perhaps including flexion-extension radiographs in the prechemonucleolysis work-up might help to identify those patients with preexisting instability who may be prone to the development of spasms.

As mentioned previously 134 of our patients came from Puerto Rico to Titusville to have the procedure performed. The results in this group were practically identical to the patients from the United States. The only difference noted, aside from the obvious cultural, social and geographical ones, was that the Puerto Rican group had a mean duration of symptoms of 29 months. This was more than twice that of the mainland group; therefore, the length of duration of symptoms preoperative did not make much difference in the final result.

It is interesting that patients under workmen's compensation did not differ significantly from those not under compensation. We believe that what made the difference was careful patient selection.

We cannot overlook the economic impact of chemonucleolysis. When compared to conventional laminectomy there is at least a 50% saving even when done as an inpatient procedure. When done as outpatient the cost reduction can be more substantial.

Conclusion • Chemonucleolysis provides us with a safe and effective therapeutic method for the patient with a herniated lumbar disc who has not responded to conservative management. In the hands of a surgeon experienced in the technique and meticulous in selection of patients, we can expect results comparable or surpassing other operative methods.

References

1. Jansen, E.F. and Balls, A.K.: Chymopapain: New Crystalline Proteinase from Papaya Latex, J. Biol. Chem. 137:459-460, 1940.
2. Stern, I.J.: Biochemistry of Chymopapain, Clinical Orthopedics and Related Research 67:42-46, 1969.
3. Garvin, P.J.; Jennings, R.B.; Smith, L., et al: Chymopapain: Pharmacologic and Toxicologic Evaluation in Experimental Animals, Clin. Orthop. 41:204-223, 1964.
4. Hirsch, C.: Studies on Pathology of Low Back Pain, J. Bone Joint Surg. 41-B:237-243, 1959.
5. Smith, L.: Enzyme Dissolution of Nucleus Pulposus in Humans, JAMA 187:137-180, 1964.
6. Smith, L.; Garvin, P.J.; Gesler, R.M., and Jennings, R.B.: Enzyme Dissolution of Nucleus Pulposus, Nature 198:1311, 1963.
7. Brown, M.D.: Chemonucleolysis with Disease, Spine 1:115-120, 1976.
8. McCulloch, J.A.: Chemonucleolysis, Bone Joint Surg. 59-B:45-52, 1977.
9. Smith, L.: Chemonucleolysis, J. Bone Joint Surg. 54-A:1795, 1972.
10. Sussman, B.J.: Experimental Discolysis, Clinical Orthopedics and Related Research 80:181-190, 1971.

• Dr. Rojas, 1855 Medical Drive, Titusville 32796.

Efficacy of cryotherapy in the treatment of human papilloma virus infection of the uterine cervix

Guy Benrubi, M.D., Robert C. Nuss, M.D., Kay Holmes, M.D. and Nancy Lammert, M.D.

ABSTRACT: Evidence of human papilloma virus infection is found in 1% of all cervical exfoliative cytology smears. The appropriate treatment for the disease is enigmatic. In order to determine the efficacy of one possible modality, 44 patients with biopsy confirmed mild dysplasia of the uterine cervix treated with cryotherapy were reviewed. The biopsies were reclassified as human papilloma virus associated lesions using accepted criteria. After treatment with cryotherapy, the patients were followed with Papanicolaou smears for a minimum of one year. Thirty five of the 44 patients had a normal cytological evaluation at three months and 30 continued to have normal cytology at one year. Nine of the 44 patients had abnormal cytology at the three-month follow-up evaluation. There were no complications associated with the use of cryotherapy. This modality appears to have some efficacy in treatment of these lesions. Further studies are necessary in order to determine the appropriate management of women with human papilloma virus infection of the uterine cervix.

The Authors
GUY BENRUBI, M.D.
ROBERT C. NUSS, M.D.
KAY HOLMES, M.D.
NANCY LAMMERT, M.D.
Dr. Benrubi is Assistant Professor, Division of Gynecologic Oncology; Dr. Nuss is Associate Professor, Director, Division of Gynecologic Oncology; Dr. Holmes is OB-GYN Resident; and Dr. Lammert is Assistant Professor, Department of Pathology at University Hospital of Jacksonville.

Until recently human papilloma virus (HPV) of the uterine cervix was considered to be uncommon.[1] There were only ten reported cases of *Condylomata acuminatum* of the uterine cervix prior to 1952.[2] Current studies reveal that 1-2% of routine Papanicolaou smears show changes characteristic for HPV.[3] These lesions are appearing in the younger sexually active woman.[4]

The papilloma virus belongs to a subgroup of the family of papova viruses. The HPV particles contain double-stranded DNA molecules. Twenty-five HPV types have been identified.[5] The human papilloma viruses that involves the genital tract include types 6, 11, 16, 18 and 31. Types 6 and 11 have been found in benign genital warts. Types 16, 18 and 31 have been reported in high grade cervical intraepithelial neoplasias.[6] These lesions may represent a high risk group more prone to malignancy.[5]

The human papilloma virus lesion of the uterine cervix is a flat, colposcopically acetowhite lesion containing mild cytological atypia and many were formerly classified a CIN I.[6] These lesions have a high rate of spontaneous regression. There is a subset of these flat cervical lesions that reveal marked cytological atypia; these are more likely to progress.[7] Studies of the DNA pattern of HPV reveal two groups. Lesions that are diploid or polyploid (Type 6, 11) regress, whereas lesions that are aneuploid (Type 16, 18, 31) progress to higher grades of CIN.[7,8]

Kaufman et al issued a cautionary statement that women with HPV of the uterine cervix receive the same colposcopic evaluation, treatment and follow up as those with cervical intraepithelial neoplasia.[9] At present management of HPV of the uterine cervix is under evaluation. A recent preliminary study at this institution reported an 80% cure rate with laser vaporization of HPV

associated cervical lesions. This study was undertaken to evaluate the use of cryotherapy in the treatment of HPV lesions of the uterine cervix.

Materials and methods • Between January 1975 and December 1977, 240 women who were evaluated in the colposcopy clinic at University Hospital in Jacksonville had the diagnosis of mild dysplasia on cervical biopsy. Colposcopically directed biopsies were performed by gynecology residents under attending supervision. All biopsies were reviewed by one pathologist for the presence of human papilloma virus. The pathologist used current criteria for HPV in reclassification of the biopsies. The criteria used to distinguish between pure HPV lesions and mild dysplasia are shown in Table 1.

Those patients reclassified with pure HPV were accepted into the study. Patients were excluded from the study for the following reasons: cervical biopsies reclassified as dysplasia, metaplasia, inflammation or insufficient tissue. Three slides were unavailable for review. Reclassification of the 240 cervical biopsies revealed that 85 were "pure" HPV. The clinical records of these 85 patients were reviewed for the type of treatment modality and follow-up evaluation. Forty four of the 85 patients had both cryotherapy and cytological evaluation for a minimum of three months. Thirty five of the patients were followed for greater than one year. Forty patients were lost to follow up and one patient underwent a vaginal hysterectomy for other reasons. Cryotherapy was performed on the 44 patients on an outpatient basis. During the three years of the study, both the single freeze (four to five minutes) and the double freeze (three minute freeze, five minute thaw, three minute freeze) techniques were used. All patients were treated with the Cu-72 Frigitronics cryosurgical unit. The unit produced a temperature probe of −80 °C and used nitrous oxide as the refrigerant.

Table 1. — Histologic Features of Cervical HPV vs CIN I.

HPV
Koilocytosis
Nuclear membrane crinkling
Intact basal layer
Binucleation/multinucleation
Focal dyskeratosis
CIN I
Dysplastic chromatin pattern
Irregular clumping and clearing of nucleic abnormal mitosis
Increased number of mitotic figures in upper ⅔ of epithelium

Table 2. — Final Histological Diagnosis of Cervical Biopsies Reviewed.

Diagnosis	Number	Percent
HPV	85	35.4
HPV + CIN I	43	17.9
HPV + CIN II	5	2.1
CIN I	57	23.8
CIN II	2	0.8
CIN III	1	0.4
CIN I + CIN II	14	5.8
Metaplasia	9	3.8
Inflammation	8	3.3
Other (missing, insufficient)	16	6.7
Total	240	100

After treatment with cryosurgery, all patients were evaluated with Papanicolaou smears at three month intervals. Cryosurgical cure was defined as a normal cytological evaluation at three months and cryosurgical failure as an abnormal cytological evaluation at three months.

Results • Seventy four percent of the women in the study were black and 26% white. The age range was 17 to 54 years. The mean age was 25. Seventy nine percent of the patients were under 30 years old. The mean gravidity was 2.5 and the mean parity 2.2.

The slides of the 240 patients with the original histological diagnosis of mild dysplasia of the uterine cervix were reviewed for evidence of human papilloma virus. The histological findings are listed in Table 2. Forty four of the 85 patients with pure HPV of the uterine cervix had both cryotherapy and cytological evaluation posttreatment. After a single treatment with cryotherapy, 35 of the 44 patients (79.5%) had normal cytology (Papanicolaou smear) at three months posttreatment and nine had abnormal cytology. These results are shown in Table 3.

Table 3. — Three Month Follow Up of Patients Treated with Cryotherapy.

Papanicolaou Smear	Number Patients	Percent
Class I	35	79.5
Class I — inflammatory	1	2.3
Class II —		
mild dysplasia	3	6.8
moderate dysplasia	1	2.3
mild and moderate dysplasia	2	4.6
Class II — inflammatory atypia	2	4.6
Total	44	100

Table 4. — Follow Up of 35 Patients with Normal Cytology at Three Months Posttreatment.

Papanicolaou Smear	Number Patients
Class I — 3 months	3
Class I — 6 months	2
Class I — 9 months	1
Class I — > 12 months	29
	35

The medical records of the 35 patients with normal cytology at three months posttreatment were further reviewed to evaluate treatment results greater than three months. The results are shown in Table 4. Thirty had normal cytology for one year. Two had normal cytology at the three and six month follow-up. Three had only three month follow-up Papanicolaou smears.

This retrospective study revealed a cryotherapy failure in nine of the 44 patients with pure HPV of the uterine cervix. The medical records of these patients were reviewed for further analysis (Table 5).

Of the nine failures, one patient (R.W.) was lost to follow-up after the initial three month posttreatment evaluation.

One of the patients (Y.N.) had a Class I inflammatory Papanicolaou smear at the initial follow-up. A repeat pap smear at six months continued to reveal inflammation. She was treated with antibiotics and follow-up for two years and remained Class I non-inflammatory.

Three of the patients (B.H., J.B., N.H.) had a Class II mild dysplasia at three months after cryotherapy. Further evaluation revealed that these patients underwent repeat colposcopic evaluations. Patient J.B. had a negative colposcopy and patient N.H. had metaplasia. No further follow-up was noted. The third patient had a repeat colposcopy revealing moderate dysplasia. She was treated with a second cryotherapy and cytology remained Class I (1½ years).

Only one patient (Y.R.) had moderate dysplasia at three months after treatment. The patient continued to have Class II moderate dysplasia at a six month evaluation. No further follow-up was noted.

Of the two patients (R.W., P.B.) with Class II mild to moderate dysplasia at three months posttreatment, one had further follow-up. Patient P.B. continued to have abnormal Class II Papanicolaou smears. The patient underwent repeat colposcopy and cryotherapy after one year. She was treated with a vaginal hysterectomy after two years.

Patients M.L. and E.B. had Class II inflammatory atypia at three months after cryotherapy. M.L. continued to have Class II pap smears. The patient was recolposcoped after one year. The biopsies were consistent with severe dysplasia. The patient underwent a vaginal hysterectomy. Patient E.B. had Class I pap smears at six and nine months posttreatment.

There were minimal complications reported following cryotherapy. The most common complaint was a self-limiting vaginal discharge.

Discussion • The incidence of human papilloma virus infection of the lower genital tract has increased nearly 700% in women over the past 20 years.[10] Retrospective studies of cervical biopsies with mild to moderate dysplasia reveal that 70% of the lesions showed evidence of HPV. The results of this study reveal that 53% of the lesions originally diagnosed as mild dysplasia were reclassified as HPV associated lesions. The lower yield of the study probably results from our reviewing only lesions with mild dysplasia. Whereas the other retrospective studies have included both mild and moderate dysplasia.

Human papilloma virus of the uterine cervix represents a distinct entity. The present study reviewed

Table 5. — Follow Up of Patients with Abnormal Cytology at Three Months Posttreatment.

Patient	Papanicolaou Smear	Follow Up After Initial Abnormal Pap Smear
Y.N.	Class I — inflammation	6 months pap — inflammation 2 years — Class I (normal)
B.H.	Class II — mild	3 months — repeat colposcopy Class II — moderate 3 months — repeat Cryotherapy Pap Class I (intervals of 3 months for 1½ years)
J.B.	Class II — mild	Repeat colposcopy — negative No further follow up
N.H.	Class II — mild	Repeat colposcopy — metaplasia No further follow up
Y.R.	Class II — moderate	6 month pap — moderate dysplasia No further follow up
R.W.	Class II — mild/moderate	No further follow up
P.B.	Class II — mild/moderate	Recurrent moderate 1 yr. — repeat colposcopy 1 yr. — repeat cryotherapy TVH 1½ yrs. later 9 month pap Class I
M.L.	Class II — inflammatory atypia	6 months — Class II inflammatory atypia 9 months — Class II inflammatory atypia 12 months — repeat colposcopy Severe dysplasia — TVH
E.B.	Class II — inflammatory atypia	6 months — Class I 9 months — Class I

the use of cryotherapy in the treatment of HPV associated lesions. The results are encouraging. Greater than 79% of the patients had normal cytology at three months posttreatment and 68% at one year. This result compares favorably with the recent preliminary study at this institution. The prospective phase II study revealed an 80% cure rate of HPV of the uterine cervix with laser vaporization. Currently there are no published reports in the literature evaluating the treatment results of pure HPV; therefore, the results of this study must be compared to the treatment of cervical intraepithelial neoplasia. Cure rates for cryotherapy and laser therapy in the treatment of CIN approaches 90%.[11,12]

The results of this study indicates that cryotherapy is probably an effective therapeutic modality for cervical human papilloma virus. Cryotherapy is an economical and safe procedure. The technical expertise is easily acquired.

We have recently started work on a three-arm randomized prospective study evaluating trichloroacetic acid, cryotherapy and laser vaporization in the treatment of pure human papilloma virus of the uterine cervix.

Conclusion • Longer follow-up and further evaluation of the natural cause of HPV of the uterine cervix are needed. Cryotherapy is probably an effective treatment modality for human papilloma virus lesions of the uterine cervix. We are presently undertaking a three-arm randomized prospective study to evaluate the use of trichloroacetic acid, cryotherapy and laser therapy in the treatment of human papilloma virus of the uterine cervix.

References

1. Walker, P.; Singer, A.; et al: Prevalence of Human Papilloma Virus Antigen in Patients with Cervical Intraepithelial Neoplasis, Brit. J. Cancer 48:99-101, 1983.
2. Marsh, M.: Papilloma of the Cervix, Am. J. Obstet. Gynecol. 64:281, 1952.
3. Meisels, A and Fortin, R.: Condylomatous Lesion of Cervix and Vagina, I. Cytological Patterns, Acta Cytol. 20:505-509, 1976.
4. Ludwig, M., et al: Cervical Condylomatous Atypia and Its Relationship to Cervical Neoplasia, Am. J. Clin. Pathol. 76:255-262, 1981.
5. Symjanen, K.: Current Concepts of Human Papilloma Infections in Genital Tract and Their Relationship to Intraepithelial Neoplasia and Squamous Cell Carcinoma, Obstet. Gynecol. Survey 39:252-263, 1984.
6. Crum, C.; Hans, I., et al: Human Papilloma Virus Type 16 and Early Neoplasia, New England J. Med. 310:880-883, 1984.
7. Fu, Y.; Braun, L., et al: Histologic, Nuclear DNA and Human Papilloma Virus Studies of Cervical Condylomata, Cancer 52:1705-1711, 1983.
8. Zolen, M.: Human Papilloma Virus Linked to Cervical (and Other) Cancers, JAMA 249:2997-2999, 1983.
9. Kaufman, R.; Meisels, A., et al: Statement of Caution in Interpretation of Papilloma Virus Associated Lesions of Epithelium of Uterine Cervix, Int. J. Gyn. Path. 2:100, 1983.
10. Centers for Disease Control: Non-reported Sexually Transmitted Diseases — United States, MMWR 28:61, 1979.
11. Figge, D. and Creasman, W.: Cryotherapy in Treatment of Cervical Intraepithelial Neoplasia, Obst. Gynecol. 62:353, 1983.
12. Stafl, A.; Wilkerson, E., and Mattingly, R.: Laser Treatment of Cervical and Vaginal Neoplasia, Am. J. Obst. Gynecol. 128(2):128-136, 1977.

• Dr. Benrubi, University Hospital of Jacksonville, 655 Eighth Street, Jacksonville 32209.

Magnetic resonance imaging of postdiscogram discitis and osteomyelitis in the lumbar spine: case report

John A. Arrington, M.D., F. Reed Murtagh, M.D., Martin L. Silbiger, M.D., Glenn R. Rechtine, M.D., and Steven R. Nokes, M.D.

ABSTRACT: A case of discitis and osteomyelitis following discography is presented. Magnetic resonance imaging localized and clearly delineated the extent of infection.

The Authors
JOHN A. ARRINGTON, M.D.
F. REED MURTAGH, M.D.
MARTIN L. SILBIGER, M.D.
GLENN R. RECHTINE, M.D.
STEVEN R. NOKES, M.D.
Dr. Arrington is a Clinical Associate in the Department of Radiology; Dr. Murtagh is an Associate Professor in the Department of Radiology; Dr. Silbiger is a Professor in the Department of Radiology; Dr. Rechtine is an Assistant Professor in the Department of Orthopedics; and Dr. Nokes is a Clinical Associate in the Department of Radiology at the University of South Florida College of Medicine.

A case of discitis and osteomyelitis following discography is presented. Magnetic resonance imaging localized and clearly delineated the extent of infection.

Case report ● A 26-year-old white male presented to an outside hospital complaining of chronic low back pain which had increased in severity over the past two months and dated back to a motor vehicle accident two years previously. Workup consisted of a myelogram which was reported as normal and 3-level discography. The discograms were performed using metrizamide via a posterolateral approach at L3-4 and L4-5 and a direct posterior transdural approach at L5-S1. No evidence of disc herniation was found.

Immediately following the discogram, the patient suffered an acute increase in the intensity of his back pain with muscle spasms. He was treated conservatively with five weeks of bedrest and the pain improved somewhat but never remitted. During this time the erythrocyte sedimentation rate rose from 18 mm to 56 mm. A 99mTc-diphosphonate bone scan performed one week following discography was reported normal as was a gallium scan performed three weeks following discography.

The patient was admitted to Tampa General Hospital/University of South Florida five weeks following discography where a 99mTc-diphosphonate bone scan revealed increased uptake from the bottom of L3 vertebral body thru S1 vertebral body. A computed tomographic (CT) scan of the lumbar spine demonstrated erosive changes at the inferior vertebral endplate of L4 and the superior endplate of S1. Magnetic resonance imaging (MRI) (Figs.1A, 1B) was markedely abnormal showing obliteration of the normal disc margins from L3 to S1 and an increased T2 that was consistent with infection. A Craig needle biopsy at the body of L4 was performed with a core of bone obtained as well as aspiration of vertebral venous blood. Staphylococcus epidermidis was cultured from both the blood and one of the Craig needle specimens. Appropriate intravenous antibiotics were begun and the patient improved rapidly.

Discussion • Intervertebral disc space infection and osteomyelitis have been described well in the orthopedic literature.[1-4] The infection is usually secondary to a bacteremia with hematogenous spread of the organism to the vertebral endplate or disc. Regardless of the etiology, there is need for early diagnosis. Factors such as the latent period between onset of clinical symptoms and appearance of abnormality on conventional radiographic studies may lead to a delay in appropriate diagnosis and consequent delay of treatment. Nuclear medicine and CT findings of discitis and osteomyelitis are also well described.[5-7] These modalities have aided in earlier diagnosis of infection in the vertebral bodies, but with the high incidence of psoas and presacral abscesses associated with discitis and osteomyelitis earlier detection would be advantageous. In the case of chemonucleolysis, it is difficult to determine if the CT changes, such as vertebral endplate irregularity, are due to infection or local reaction to the chemopapain.[8]

MR seems to be at least as sensitive in the early detection of inflammatory or neoplastic changes in the vertebral bodies and discs as radionuclide scans and the anatomical representation is more detailed.[9-12] The increased T1 and T2 signals are attributable to increased water content in the marrow of the affected vertebral bodies. The anatomic separation of disc material from vertebral bodies normally seen with T1-weighted MR sequences is lost, but enough anatomical information remains to reveal that no encroachment upon the spinal canal or epidural abscess is present in this case. Moreover, the T1 and T2 abnormalities are so well delineated and localized that we were able to direct the Craig needle to the appropriate site for optimal biopsy results. In patients at risk for osteomyelitis or discitis, MR should be the imaging modality of choice to evaluate the spine. This patient population includes urologic instrumentation in patients with urinary sepsis and patients on dialysis or with indwelling IV catheters. Chemonucleolysis and discography also carry a risk of infection.[1] MR provides the anatomical detail necessary to evaluate the extent of infection as well as the sensitivity for early detection.

References

1. Stauffer, R.N.: Pyogenic Vertebral Osteomyelitis, Orthop. Clin. North. Am. 6(4) 1015-1027, 1975.
2. Digby, J.M. and Kersley, J.B.: Pyogenic Non-Tuberculous Spinal Infection, J. Bone Joint Surg. (Br.) 61 47-55, 1979
3. Kemp, H.B., Jackson, J.W., Jeremiah, J.D., and Hall, A.J.: Pyogenic Infections Occurring Primarily in Intervertebral Discs, J. Bone Joint Surg. (Br.) 55:698-714, 1973
4. Wiley, A.M. and Trueta, J.: Vascular Anatomy of Spine and Its Relationship to Pyogenic Vertebral Osteomyelitis, J. Bone Joint Surg. (Br.) 41.796-809, 1957

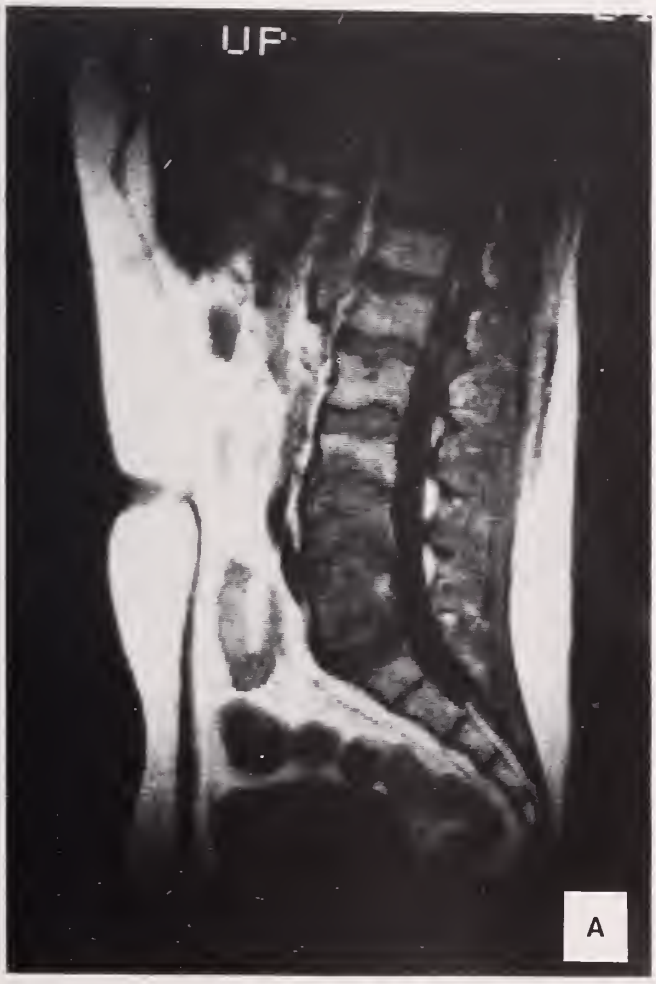




Fig. 1. — A and B sagittal MR with T1 and T2 weighted sequences respectively. These show areas of both increased T1 and T2 involving the caudal half of vertebral body L3, all of L4 and L5, and the cephalic half of S1, all consistent with inflammation in this case.

5. Golimbu, C.; Firooznia, H., and Rafii, M.: CT of Osteomyelitis of Spine, AJR 142:159-163, 1984.
6. Price, A.C.; Allen, J.H.; Eggers, F.M., and James, A E.: Intervertebral Disk-Space Infections: CT Changes, Radiology 149:725-729, 1983.
7. Larde, D.; Mathieu, D.; Frija, J.; Gaston, A., and Vasile, N.: Vertebral Osteomyelitis: Disk Hypodensity on CT, AJR 139:963-967, 1982.
8. Deeb, Z.L.; Schimel, S.; Daffner, R.H.; Lupetin, A.R.; Hryshko, F.G., and Blakley, J.B.: Intervertebral Disk-Space Infection After Chymopapain Injection, AJR 144:671-674, 1985.
9. Modic, M.T.; Feiglin, D.H.; Piraino, D.W.; Boumphrey, F.; Weinstein, M.A.; Duchesneau, P.M., and Rehm, S.: Vertebral Osteomyelitis: Assessment Using MR, Radiology 157:157-166, 1985.
10. Han, J.S.; Benson, J.E., and Yoon, Y.S.: Magnetic Resonance Imaging in Spinal Column and Craniovertebral Junction, Rad. Clin. N. Am. 22(4):805-827, 1984.
11. Brant-Zamadski, M.: Magnetic Resonance Imaging: Abnormal Brain and Spinal Cord. Chapter 7 in Advanced Imaging Techniques, eds. T.H. Newton and D.G. Potts, Clavadell Press, San Anselmo, CA, 1983.
12. Genant, H.K.; Moon, K.L.; Heller, M.; Chafetz, N.I., and Helms, C.A.: Nuclear Magnetic Resonance: Musculoskeletal Applications, Spine Update 1984, San Francisco, California, 1984, pp. 359-382.

● Dr. Arrington, University of South Florida College of Medicine, 12901 N. 30th St., Box 17, Tampa 33612.

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

MASTER APPROACH TO CARDIOVASCULAR PROBLEMS

Fourteenth Annual Conference

THE CONTEMPORARY RESORT HOTEL
WALT DISNEY WORLD
EPCOT CENTER
Lake Buena Vista, Florida
May 24, 25 & 26, 1986
MEMORIAL DAY WEEKEND

Guest Speakers:

Geoffrey O. Hartzler, M.D.

Present Status of Coronary Angioplasty

J. Willis Hurst, M.D.

What is a Cardiologist in 1986?

Nanette Kass Wenger, M.D.

State of the Art in Cardiac Rehabilitation

UNIVERSITY OF MIAMI FACULTY:

Agustin Castellanos, M.D.
Bernard J. Fogel, M.D.
Stephen M. Mallon, M.D.
Robert J. Myerburg, M.D.
J. Maxwell McKenzie, M.D.

For more information please call (305) 549-7124 or complete coupon and mail to: Y. Barcena, Cardiology (D-39), University of Miami School of Medicine, P.O. Box 016960, Miami, Florida 33101.

Please send me more information regarding
"MASTER APPROACH TO CV PROBLEMS"

Name _____

Phone () _____

Address _____

Immediate Florida Practice Opportunity In . . .

NEUROSURGERY

We are seeking two (2) board certified neurosurgeons for the Florida office of a nationally-known group practice and multi-hospital system.

Candidates should have an exceptional record of clinical practice, a strong interest in continuing medical education, and a commitment to personal care in a group practice setting.

Prior teaching experience, professional publications and a current Florida license would be desirable.

Physicians wishing to express an interest should send a cover letter with career objectives, and a complete curriculum vitae to:

Box # C-1322
Florida Medical Association
P.O. Box 2411
Jacksonville, FL 32203

All inquiries will be answered in confidence.

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

THE MEDICAL SYSTEM INCLUDES:
- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

ADVANTAGES
- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

INTERESTED?
For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

The ISI Software Question

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.

Proccedings Interim Meeting Florida Medical Association House of Delegates Tampa, January 25-26, 1986

The Interim Meeting of the First House of Delegates was called to order at 8:45 a.m. on Saturday, January 25, 1986 at the Lincoln Hotel, Tampa, Florida, by Guy T. Selander, M.D., Speaker.

The House was invited to stand for the singing of the Star Spangled Banner, played by Joseph T. Ostroski, M.D., and the Pledge of Allegiance to the Flag, and to remain standing for the invocation which was lead by Charles J. Kahn, M.D.

Dr. Selander announced the membership of the Credentials Committee:

H. Murray Todd, M.D.
Wilbert L. Dawkins, M.D.
Robert G. Isbell, M.D.

The Delegates were reminded that they must register with the Credentials Committee before this meeting of the House of Delegates.

H. Murray Todd, M.D., Chairman of the Credentials Committee, announced that 205 Delegates were present, representing 44 component county medical societies, which constitutes a quorum.

A motion carried to seat the Delegates. A motion was also carried to a adopt the Rules and Order of Business.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Robert K. Casey, M.D.; Elayne E. Cassisi, M.D.; James O. Dailey, M.D.; W. Thomas Hawkins, M.D.; Thomas H. Moore, M.D.; Mr. David Campbell, Student

BAY — James T. Cook III, M.D., Terrence R. Steiner, M.D. (Absent — B. Philip Cotton, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D.; Raymond A. Armstrong, M.D.; Richard I. Barr, M.D.; Onofre P. Carrillo, M.D.; Brian J. Ellis, M.D.; Howard W. Pettingill, M.D.; Robert C. Ufferman, M.D.

BROWARD — George T. Edwards, M.D.; Paul A. Flaten, M.D.; Peter D. Gegerson, M.D.; Theodore W. Hahn, M.D.; John M. Harper, M.D.; William C. Hartley, M.D.; George P. Messenger, M.D.; Ray E. Murphy Jr., M.D.; Donald J. Plevy, M.D.; Emilio San Martin, M.D.; Marvin L. Stein, M.D.; H. Murray Todd, M.D.; Robert G. Weber, M.D.; Juan S. A. Wester, M.D.; (Absent — Walter A. Campbell, M.D.; Andre S. Capi, M.D.; Phillip A. Caruso, M.D.; Thomas E. Corley, M.D.; George J. Crane, M.D.; David A. D'Alessandro, M.D.; Ira Finegold, M.D.; Stanley S. Goodman, M.D.; Wayne R. Johnson, M.D.; Jerry D. Moore, M.D.; Joseph M. Sachs, M.D.; Ernest G. Sayfie, M.D.; Richard D. Shafron, M.D.; Arnold L. Tanis, M.D.; Alan J. Yesner, M.D.)

CAPITAL — Robert P. Johnson, M.D.; William Hutchison, M.D.; Jack W. MacDonald, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.; (Absent — Thomas R. Civitella, M.D.)

CITRUS — W. Randall Jenkins, M.D.; (Absent — Samuel R. Miller, M.D.)

CLAY — Darrell W. Wyatt, M.D.

COLLIER — Charles S. Eytel, M.D.; Donald W. Ketterhagan, M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — (Absent — Nanjunda Swamy, M.D.)

DADE — Edward R. Annis, M.D.; Jerome Benson, M.D.; Pedro P. Bosch, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; William P. Calvert, M.D.; O. William Davenport, M.D.; Charles A. Dunn, M.D.; Miguel Figueroa, M.D.; Denio O. Fonseca, M.D.; Simon J. H. Frank, M.D.; Richard L. Glatzer, M.D.; Joseph Harris, M.D.; James J. Hutson, M.D.; Maurice H. Laszlo, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda A. Marraccini, M.D.; Sheldon, D. Munach, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; Daniel L. Seckinger, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Bruce W. Weissman, M.D.; George Markovich, Student; (Absent — Virgilio I. Beato, M.D.; James W. Bridges, M.D.; John O. Brown, MD.; Harlan S. Chiron, M.D.; Vincent P. Corso, M.D.; Joseph H. Davis, M.D.; Norman T. Ditchek, M.D.; N. Ralph Frankel, M.D.; Antonio F. Frexes, M.D.; Donald E. Johnson, M.D.; Sean M. Kaufman, M.D.; Horace A. Leyva, M.D.; Warren Lindau, M.D.; Charles A. Monnin, M.D.; Miguel A. Mora, M.D.; Dolores A. Morgan, M.D.;

Harry T. Remmer, M.D.; Oscar Sandoval, M.D.; A. Frederick Schild, M.D.; Margaret C. S. Skinner, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokley, M.D.; Charles F. Tate, M.D.; Claudio R. Villoch, M.D.; Steven M. Weissberg, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Clyde M. Collins, M.D.; James H. Corwin II, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; Marc D. Kaye, M.D.; John F. Lovejoy Jr., M.D.; Kevin M. McAuliffe, M.D.; Charles B. McIntosh, M.D.; Charles T. Montgomery, M.D.; Sanford A. Mullen, M.D.; H. Warner Webb, M.D.; (Absent — William P. Booras, M.D.; Walter A. Harmon, M.D.; Faris S. Monsour Jr., M.D.; Kurt W. Mori, M.D.; John A. Rush, M.D.; Seabury D. Stoneburner Jr., M.D.; George S. Trotter, M.D.; James W. Walker, M.D.)

ESCAMBIA — Paul T. Baroco, M.D.; Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; James M. Potter, M.D.; Henry M. Yonge, M.D.; William J. Whidds, M.D.

FLAGLER — (Absent — John M. Canakaris, M.D.)

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew, M.D.

HIGHLANDS — Richard G. Spindler, M.D.; (Absent — Eustus S. Nelson, M.D.)

HILLSBOROUGH — Dennis A. Agliano, M.D.; Richard A. Bagby, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Hernan Leon, M.D.; Thomas A. McKell, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; (Absent — Ralph E. Rydell, M.D.; H. Stewart Siddall, M.D.; Harold L. Williamson, M.D.; Mr. T. Roland Reeves, Student)

INDIAN RIVER — Paul Graham, M.D.; David Griffin, M.D.; Kip G. Kelso, M.D.

LAKE — Joseph E. Holland Jr., M.D.; Robert H. Hux, M.D.; (Absent — Joseph A. Comfort, M.D.)

LEE — Robert J. Brueck, M.D.; Joseph P. Fiore, M.D.; Larry P. Garrett, M.D.; F. Lee Howington, M.D.; H. Quillian Jones Jr., M.D.; Douglas A. Newland, M.D.

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D.; (Absent — William A. Boyce, M.D.; Robert A. Fasoli, M.D.; Julian Giraldo, M.D.; Roger A. Meyer, M.D.)

MARION — Claude B. Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Andrew F. Greene, M.D.; James M. Hayes, M.D.; (Absent — Fred S. Carter, M.D.)

MONROE — (Absent — Ronald H. Chase, M.D.)

NASSAU — (Absent — Robert L. Taylor, M.D.)

OKALOOSA — William W. Thompson, M.D.; (Absent — David R. Arrowsmith, M.D.)

ORANGE — Francis M. Coy, M.D.; Wayne L. Godbold, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Robert N. Serros, M.D.; Thomas Scott, M.D.; Cecil B. Wilson, M.D.; (Absent — Edward Ackerman, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; David L. Mackey, M.D.; Calvin R. Peters, M.D.; Wallace M. Philips Jr., M.D.; Philip N. Styne, M.D.; T. Byron Thames, M.D.)

OSCEOLA — John R. Hartman, M.D.; Alonzo J. Logan, M.D.

PALM BEACH — E. Joan Barice, M.D.; Richard C. Cavanagh, M.D.; McKinley Cheshire, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Gilbert R. Panzer, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; (Absent — Vernon B. Astler, M.D.; Robert Burger, M.D.; George L. Ford Jr., M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; William J. Romanos Jr., M.D.; Joel F. Smith, M.D.; Ben R. Thebaut Jr., M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Vincent G. Cotroneo, M.D.; Carl W. Graves, M.D.; Maynard F. Taylor, M.D.

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony P. Garritano, M.D.; William E. Hale, M.D.; John Hamilton, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris LeVine, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Howard L. Reese, M.D.; William H. Schmid, M.D.; Bruce P. Smith, M.D.; Walter H. Winchester, M.D.

POLK — Richard M. Garcia, M.D.; John W. Glotfelty, M.D.; Thomas E. McMicken, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; Daniel W. Welch, M.D.; (Absent — Ronald W. Case, M.D.; David T. Jones, M.D.)

PUTNAM — Roy E. Campbell, M.D.

ST. LUCIE-OKEECHOBEE — Khalil A. Cassimally, M.D.; Manuel G. Garcia, M.D.; (Absent — David L. Fromang, M.D.)

SANTA ROSA — David B. Young, M.D.

SARASOTA — Jack E. Baron, M.D.; William E. Bush, M.D.; John N. Carlson, M.D.; Robert W. Dein, M.D.; Kenneth C. Kiehl, M.D.; Frank H. Pfeiffenberger, M.D.; Karl R. Rolls, M.D.; Ernest C. Smith Jr., M.D.; (Absent — David L. Thomas, M.D.)

SEMINOLE — Maria P. Perez, M.D.; (Absent — Humberto A. Dominguez, M.D.; Orlando Garcia-Piedra, M.D.)

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — (Absent — John H. Parker, M.D.)

VOLUSIA — Harry F. Farmer, M.D.; Richard H. Huster, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.; H.S. Budd Treloar, M.D.

WALTON — (Absent — James G. Leker, M.D.)

WASHINGTON — (Absent — Muhammad I. Zafar, M.D.)

SPEAKER OF THE HOUSE — Guy T. Selander, M.D.

VICE-SPEAKER — Arthur L. Eberly Jr., M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

SPECIALTY GROUPS — Michael Alberts, M.D.; Joseph A. Baird, M.D.; Paul H. Bridgeford, M.D.; Richard Chidsey, M.D.; George A. Gant, M.D.; Ira Gessner, M.D.; David A. Giordano, M.D.; Mutaz Habal, M.D.; Jerry L. Harris, M.D.; Robert Hoover, M.D.; T. T. Knight Jr., M.D.; Louis R. Kurland, M.D.; Donald S. Kwalick, M.D.; Clifford Lober, M.D.; Robert T. Meade, M.D.; Robert K. Middlekauff, M.D.; Jimmie D. Moore, M.D.; Arthur Pearl, M.D.; Sylvan H. Sarasohn, M.D.; Daniel J. Schwartz, M.D.; Malvin Wineberger, M.D.

Remarks — Speaker of the House

Good morning and welcome to the 1986 interim meeting of the Florida Medical Association. In view of the abbreviated format of this meeting, your Speaker has decided to forego this golden opportunity to wax eloquent, and to encourage brevity when possible, among my distinguished colleagues on the platform as well.

With this theme in mind, it is not our intent to stifle discussion, but to get on with the Association's business. The House of

Delegates, at this interim meeting, will consist of two sessions (this one and the second meeting tomorrow morning). We will have our reference committee, which will be chaired by Lee Fischer, M.D., of Palm Beach County, and will meet immediately following this First meeting of the House in this room.

Each delegate is required to register for each meeting of the House by filling out an attendance card. Our deliberations are governed by *Sturgis Standard Code of Parliamentary Procedure*, which guidelines will prevail unless otherwise provided in the FMA Charter and Bylaws. The rules and order of business (in the handbook) will be followed unless waived by a two-third majority of delegates seated. I will call for this adoption after the President's address.

Any member of the FMA may speak at the Reference Committee, and it is in this forum — The Reference Committee — that debate is encouraged. When all have been heard and each item referred to the Reference Committee has been thoroughly massaged, the Reference Committee will adjourn to executive session to prepare its report to the House of Delegates on Sunday. It is our intent to have one copy of the Reference Committee report available for each county medical society that wants one by 6 p.m. today. The delegates' copies will be ready early tomorrow morning.

In view of the opportunity for each delegate to speak at the Reference Committee, you are encouraged to be concise and make pertinent remarks when compelled to further discuss any of the issues on the floor of the House during the Second meeting.

Nominations for AMA delegate and alternate delegate will be accepted later on in this meeting, and the election process will be explained then.

We have a busy two days ahead of us. Work hard and we will get through it.

Thank you.

At this time, Dr. Selander proceeded to introduce FMA President Luis M. Perez, M.D.

Dr. Perez then addressed the House.

Remarks of the President

Mr. Speaker, fellow delegates, ladies and gentlemen. It is indeed a pleasure to speak to the House making my first address as acting President. Since May we have been visiting medical societies throughout the State, and forming coalitions and seeing groups for different reasons. One of our first meetings was at the end of last year when we went to see the Speaker of the House and the President of the Senate to find out what was the perspective for the upcoming year and the next Legislative Session. The Speaker of the House told us clearly and concisely that he had done everything that he was going to do for malpractice last year, and that he had solved the problem. Also for this year, if we wanted anything done in the area of malpractice we have to prove to him that there is a crisis. The President of the Senate was not so blunt — as he is running for Governor — but he expressed the same feelings. He took alot of notes and told us that the Senate had done everything they were going to do last year, and the issue would probably not even be brought to the floor this year. So right then, in the month of October, we began to look for ways to show the House of Representatives and the Senate that there is a crisis. Right then, we began a campaign to involve the majority of Florida doctors going to Tallahassee for the purpose of proving to the Legislature that there is a crisis.

At the same time things started hopping all over the State. As you well know, there is a crisis in other types of liability; so much so that the trial attorneys of the United States — their AMA of trial attorneys — met together in Orlando last week to discuss the possibility of fraud on the part of the insurance companies, making them guilty for the crisis in the courts. They do not mention the "bad doctor" anymore. The bad doctor is out because he cannot be related to the sheetmetal worker or the roofer whose insurance premiums have gone so high. So now they are talking about the insurance companies ripping off the people. That is the reason we have a crisis in liability — thank God they have turned us loose. Using this, we met in Orlando with the heads of 60 organizations who are dealing with this liability crisis to try to form a coalition to go together to Tallahassee to ask for relief for the problems we are having with liability. We formed a committee from this coalition, that will meet in February to amalgamate all these different industries. On the 13th of February we will meet again to delineate the actions that we will take. On April 21st, we will stage a "March on Tallahassee." We have rented the Civic Center in Tallahassee to meet with the interested parties. We are not rebel rousers, we are not going to yell and scream, and we are not going to create confrontations. We simply are going to ask the legislators to give us relief. We will probably have the sheetmetal workers working with us, as well as the roofers, the elevator and escalator people, the baby nurseries, the bowling alley people — you name it. Everybody is having a problem with liability and everybody wants to participate in this march.



FMA President, Luis M. Perez, M.D., addresses the House of Delegates while Donald C. Jones, Executive Vice President, Henry M. Yonge, M.D., Secretary, and Guy T. Selander, M.D., Speaker of the House look on.

At the same time, I would like to ask the Ob/Gyn's present to do me a favor by trying to convince your medical society to sponsor a group of pregnant women to participate. If we can get between 200 and 300 to join us in Tallahassee, that would be extremely effective with the legislators. An expectant mother can tell a legislator that she has to go 30 miles to see her doctor because there is no doctor in her town delivering babies due to all the family practitioners who used to deliver babies quit because of the malpractice premiums. Or she could tell the legislator that this baby is going to cost her $1,500.00 when the last one only cost $700.00 because the doctor had to raise his prices to cover his malpractice premium. Then the legislators will realize that there is a crisis and they will have to do something about it.

As you know, we are asking the Legislature for a cap of $250,000.00 for noneconomic damages, we are asking for a repeal of joint and several liability and we are asking them for a repeal of the mandatory insurance for practicing medicine. We believe that the last issue is an immoral and abusive one. To me, it is as if I told you that you should have life insurance to protect your wife

and children. If you tell me no, you do not want life insurance then I would tell you that you could not live — and then I would shoot you. Well, that is exactly what they are doing with my professional career with mandatory malpractice insurance. It is as if I killed you because you do not have life insurance. They are killing me professionally exactly the same way. I believe this is immoral and we have to fight it. I expressed my feelings to the legislators and they understood. We have problems with the semiretired physicians who have to give up their licenses because they cannot afford insurance premiums, as well as part-time physicians, many of whom are women. The sometimes do not make enough money to pay the secretary, let alone the insurance.

So we have to finish with this, hopefully by this demonstration we are planning. We will have shuttle buses going to the Civic Center to the Capital and back again, as well as shuttle buses from the airport to the Civic Center and back. Food will be provided.

We must limit our discussions at this meeting to only the problems we have with the malpractice legislation. However, the malpractice problem is not our only issue this year. We have more serious problems other than malpractice. I do not know how many of you realize that this year we are going to have the sunset of all the health care acts. Medicine, pharmacy, nursing, chiropractors — every one of the health careers is going to sunset this year and they are going to rewrite all these acts, or reaffirm what was in the act previously. We have to constantly monitor this rewriting. We have to go to these committees and be completely sure of what they are doing. We do not want anything put in or taken out of an act that we will not accept. Therefore, it is going to be an uphill battle for the people in Tallahassee.

Thus I am going to need everyone of you to help us with this. The Board of Directors and myself, along with our extremely efficient and hardworking personnel in Tallahassee, do not have enough people to cover everything. We have hired consultants and extra people when things became too tough. But we need the warm bodies of physicians in Tallahassee, testifying, talking to the legislators in a polite, intelligent way, and convincing them. Remember that in Tallahassee you achieve things three ways: One is by the golden rule — he that has the gold makes the rules — we do not have enough gold to make the rules, that is obvious.

Secondly, by persuasion, by talking to your local legislator, and trying to persuade him of the problem we are having. Do not demand, do not abuse, do not use nasty words or write nasty letters as they are very hard to retract later. We are supposed to just teach them what they do not know. Most of them are not doctors, but they are businessmen, and everyone of them has their own problems with liability. We have to teach them what our problem is. Tell them how many doctors leave your state, your county; how many doctors constrict their practice and discontinue serious procedures; how many doctors are afraid to work in an emergency room. Explain it to them, convince them that we are having a very serious problem — doctors are leaving the state, doctors are exchanging a specialty and doctors are diminishing the amount of service given to the people of Florida because they are a afraid of the malpractice crisis. Once they understand that, the Legislators will move.

The third way to convince them is by force and that is what we are going to do the 21st of April — use force, while at the same time going there and talking with them. The number of people in our group will be forceful enough. However, I hope there will be over 5,000 doctors, otherwise it will do no good. A handful of us will not accomplish a thing. We have to have over 5,000 people. If we have 5,000 doctors in Tallahassee with our 200 or 300 pregnant women walking around the halls of the Capital we may achieve our goal. We must give them the impression that doctors are not just coming to Tallahassee for one day, giving up one day of work from their practice, but that in November these same doctors will be extremely active politically in their own counties, and that we may be able to unseat the legislators that vote against us all the time. We are not just going to insinuate this, but make it very clear that the doctors are mad, the doctors are not going to take it any longer, and the doctors are going to be active politically.

At the same time occasionally I am going to need you to come to Tallahassee to testify in the different practice acts. I want you to be sure that you are available in a very short notice. We will try to pick delegates from the FMA to testify in Tallahassee that are the most knowledgeable individuals we have about the political arena and the political problems in the state. We want to use your expertise, your worthiness, and your ability to speak. Now the fight is going to be uphill because, as I told you, the leadership does not have sympathy for us at the moment. But I think they will have to have it, if we all get together and do the things together, and do not try to divert our house in any way, shape or form. If we all pool our efforts, there is no one who can stop us. And, I am sure that this year these limited goals that we put on ourselves will be achieved without too much problem. If they are not achieved — and that could happen because one can never know what will happen in the Legislature — we have to be ready to run a very strong campaign in November to unseat the individuals which are interfering with our livelihood. We have to use the political arena. We have to help the candidate of our choice against the individual who is stopping us from achieving complete freedom in our profession. In the future, we are going to have to set up the seats and start working toward our constitutional amendment in 1988 in which we are going to have only one proposition. That proposition is going to aimed at getting all the liability problems out of the tort system. We are going to do it in a contractual form with a binding arbitration type of thing, like a type of workers' compensation or no-fault insurance. All this is in the making; it has been worked out, and as you can see we are proposing new plans for the short term now, in this Legislative Session, and the long term for 1987 and '88. This is the way we are going to go if this House approves our propositions.

Thank you very much.

Before considering the adoption of the Rules and Order of Business, Dr. Selander introduced Resolution 86-19 regarding opening up the meeting to other than legislative issues. The Speaker and Vice Speaker accepted this as a motion to suspend the rules. Harold Norman, M.D., Dade County, read the resolution. A two-third majority vote was not obtained, therefore Resolution 86-19 was not adopted.

The Speaker then introduced the Speaker's Table: Arthur L. Eberly, M.D., Vice Speaker; Luis M. Perez, M.D., President; James B. Perry, M.D., President-Elect; Frank C. Coleman, M.D., Immediate Past-Presidnet; James G. White, M.D., Vice-President; Henry M. Yonge, M.D., Secretary; Donald C. Jones, Executive Vice President.

Dr. Selander turned the podium over to Dr. Eberly, Vice Speaker, for the introduction of distinguished guests. Dr. Eberly introduced Edward Annis, M.D., Past President AMA, Mrs. Jo Tignor, President FMA Auxiliary, and Mrs. Susan Marks, President-Elect FMA Auxiliary.

Dr. Eberly informed the House of the corrections to the Handbook as follows:

On page 3, about half way down the page, the second time "Council on Legislation" appears should be "Council on Medical Economics."

On page 17, just before the paragraph beginning "One delegate and one alternate. . .," please insert "Nominations for Delegate and Alternate to American Medical Association."



Pictured are the FMA Officers. Standing: Guy T. Selander, M.D., Speaker of the House, Jacksonville. Sitting left to right: Arthur L. Eberly Jr., M.D., Vice Speaker, Lighthouse Point; Luis M. Perez, M.D., President, Sanford; James B. Perry, M.D., President-Elect, Fort Lauderdale; James G. White, M.D., Vice President, Ormond Beach; Yank D. Coble Jr., M.D., Treasurer, Jacksonville; Frank C. Coleman, M.D., Immediate Past President, Tampa.

On page 18, following "Report of Reference Committee No. I, Legislation and Miscellaneous," is the Announcement of Election Results.

On the first of the page of the Board Report on line 34, correct the spelling of the last word to "crisis."

On the same page, line 53 and 54, where Section 458.331 appears three times in the paragraph, should be 458.313 in all three places.

On the last page of the Board Report, line 82, the word "Billing" (coalition billing) should be "Building."

Dr. Eberly announced the members of Reference Committee No. I and the time that the Reference Committee would meet.

Reference Committee No. I
Legislation and Miscellaneous

Lee A. Fischer, M.D., Chairman, Palm Beach
Eric F. Geiger, M.D., Escambia
Charles T. Montgomery, M.D., Duval
Glenn S. Hooper, M.D., Hillsborough
David A. Giordano, M.D., Sarasota
H. Quillian Jones Jr., M.D., Lee
Robert N. Serros, M.D., Orange
Theodore W. Hahn, M.D., Broward
Harold G. Norman, M.D., Dade

Dr. Eberly announced that the assignment of Board Reports and Resolutions as published in the Handbook will be referred to Reference Committee No. 1 and assignments of Supplemental Reports and resolutions received too late for inclusion in the Handbook, are in the Delegates packets and also referred to Reference Committee No. 1.

A motion was made and seconded to adopt the Rules and Order of Business of the House of Delegates. The motion passed.

Information for Delegates

The Rules and Order of Business for the House of Delegates are included in this Handbook.

The purpose of this meeting of the House is "to consider a report and recommendations from the Board of Governors regarding the Association's 1986 legislative program for professional liability and to consider a report and recommendations from the Board on other issues of timely import; and, further, that an election be held at that time to elect a twelfth Delegate and Alternate Delegate to the AMA House of Delegates for a term of two years expiring December 31, 1987, and any other seats that may be vacant at that time."

Delegates whose names appear in this Handbook are those who were seated at the 1985 Annual Meeting of the House of Delegates, or are as designated by the respective county medical societies and specialty groups. The Bylaws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance. Please note that even though a delegate registers separately for the Leadership Conference it will be necessary to register again with the Credentials Committee before each meeting of the House. The Chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

The deadline for receipt of resolutions is noon Friday, January 24, 1986. Presentation of any reports or resolutions after this deadline will require the unanimous consent of the House, must be of an emergency nature, and must be in writing.

Your attention is called to the format of the Meeting, where the Reference Committee meeting will be held immediately following the First Meeting of the House. The chief purpose of Reference Committees is to allow an opportunity for as many members of the Florida

Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates.

According to our Bylaws, nominating speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in which they may be of assistance to any member of the Florida Medical Association.

Guy T. Selander, M.D., Speaker
House of Delegates

Arthur L. Eberly Jr., M.D., Vice Speaker
House of Delegates

Dr. Selander announced that any business to be considered by the House must have been submitted by 12:00 Friday, January 24. Presentations of any other reports or resolutions not already on the agenda will now require the unanimous consent of the House. It would have to be of an emergency nature and in writing. There were no such reports.

Dr. Selander announced the procedures for elections. The elections will be for one delegate and one alternate to the House of Delegates, American Medical Association, for a two-year term beginning January 1, 1986, and expiring December 31, 1987.

Dr. Selander took nominations for AMA Delegate Seat 12. J. Lee Dockery, M.D., was nominated by Alachua County Medical Society and the nomination was seconded. Seeing no other nominations, the chair declared Dr. Dockery elected.

Alvin E. Smith, M.D. was nominated for Alternate Seat 8 which was vacated by Dr. Dockery when he was elected to Delegate Seat 12. Dr. Smith was nominated by Volusia County Medical Society and the nomination was seconded. Seeing no other nominations, the chair declared Dr. Smith elected.

Henry M. Yonge, M.D., was nominated for Alternate Seat 12 by Charles J. Kahn, M.D., and the nomination was seconded. Seeing no other nominations the chair declared Dr. Yonge elected.

Dr. Selander informed the House that elections would not take place as previously announced.

Dr. Selander made several announcements. The House recessed at 9:50 a.m. to reconvene on Sunday, January 26, 8:30 a.m.

Second House of Delegates

The Interim Meeting of the Second House of Delegates was convened at 8:45 a.m., Sunday, January 26, 1986, at the Lincoln Hotel, Tampa, Florida, with Arthur L. Eberly Jr., M.D., Vice-Speaker of the House presiding.

H. Murray Todd, M.D., of the Credentials Committee reported that 204 Delegates were present with 27 component county medical societies represented, constituting a quorum, and moved that the Delegates be seated. The motion carried.

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Robert K. Casey, M.D.; Elayne E. Cassisi, M.D.; James O. Dailey, M.D.; W. Thomas Hawkins, M.D.; Thomas H. Moore, M.D.; Mr. David Campbell, Student

BAY — James T. Cook III, M.D., Terrence R. Steiner, M.D. (Absent — B. Philip Cotton, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D.; Raymond A. Armstrong, M.D.; Richard I. Barr, M.D.; Onofre P. Carrillo, M.D.; Brian J. Ellis, M.D.; Howard W. Pettengill, M.D.; (Absent — Robert C. Ufferman, M.D.)

BROWARD — George T. Edwards, M.D.; Paul A. Flaten, M.D.; Peter D. Gegerson, M.D.; Theodore W. Hahn, M.D.; John M. Harper, M.D.; William C. Hartley, M.D.; George P. Messenger, M.D.; Ray E. Murphy, M.D.; Marvin L. Stein, M.D.; H. Murray Todd, M.D.; Juan S. A. Wester, M.D.; (Absent — Walter A. Campbell, M.D.; Andre S. Capi, M.D.; Phillip A. Caurso, M.D.; Thomas E. Corley, M.D.; George J. Crane, M.D.; David A. D'Alessandro, M.D.; Ira Finegold, M.D.; Staneley S. Goodman, M.D.; Wayne R. Johnson, M.D.: David C. Lane, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Joseph M. Sachs, M.D.; Ernest G. Sayfie, M.D.; Richard D. Shafron, M.D.; Donald D. Sheffel, M.D.; Arnold L. Tanis, M.D.; Alan J. Yesner, M.D.)

CAPITAL — Robert P. Johnson, M.D.; William J. Hutchison, M.D.; Jack W. MacDonald, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.; (Absent — Thomas R. Civitella, M.D.)

CITRUS — W. Randall Jenkins, M.D.; (Absent — Samuel R. Miller, M.D.)

CLAY — Darrell W. Wyatt, M.D.

COLLIER — Charles S. Eytel, M.D.; Joseph F. Sullivan, M.D.; (Absent — Virgil Ponzoli Jr., M.D.)

COLUMBIA — (Absent — Nanjunda Swamy, M.D.)

DADE — Edward R. Annis, M.D.; Jerome Benson, M.D.; Pedro P. Bosch, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Miguel Figueroa, M.D.; Richard L. Glatzer, M.D.; Pepi Granat, M.D.; James J. Hutson, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda A. Maraccini, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; Margaret C. S. Skinner, M.D.; Charles F. Tate, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Bruce Weissman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; (Absent — Manuel Abella-Fernandez, M.D.; Virgilio I. Beato, M.D.; James W. Bridges, M.D.; Harlan S. Chiron, M.D.; Vincent P. Corso, M.D.; Norman T. Ditchek, M.D.; Denio O. Fonseca, M.D.; Simon J. H. Frank, M.D.; N. Ralph Frankel, M.D.; Antonio F. Frexes, M.D.; Joseph Harris, M.D.; Donald E. Johnson, M.D.; Sean M. Kaufman, M.D.; Horace A. Leyva, M.D.; Charles A. Monnin Jr., M.D.; Miguel A. Mora, M.D.; Dolores A. Morgan, M.D.; Harry T. Remmer, M.D.; Oscar Sandoval, M.D.; A. Frederick Schild, M.D.; Daniel L. Seckinger, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokley, M.D.; Claudio R. Villoch, M.D.; Steven M. Weissberg, M.D.; George Markovich, Student)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Yank D. Coble, M.D.; Clyde M. Collins, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; Marc D. Kaye, M.D.; John F. Lovejoy, M.D.; Kevin M. McAuliffe, M.D.; Charles B. McIntosh, M.D.; Charles T. Montgomery, M.D.; Sanford A. Mullen, M.D.; H. Warner Webb, M.D.; (Absent — James Corwin II, M.D.; Walter A. Harmon, M.D.; Faris S. Monsour Jr., M.D.; Kurt W. Mori, M.D.; John A. Rush, M.D.; Seabury D. Stoneburner Jr., M.D.; George S. Trotter, M.D.; James W. Walker, M.D.)

ESCAMBIA — Paul T. Baroco, M.D.; Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; James M. Potter, M.D.; Henry M. Yonge, M.D.; William J. Whidds, M.D.

FLAGLER — (Absent — John M. Canakaris, M.D.)

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Richard G. Spindler, M.D.; (Absent — Eustus S. Nelson, M.D.)

HILLSBOROUGH — Dennis A. Agliano, M.D.; Richard A. Bagby, M.D.; Frank C. Coleman, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Hernan Leon, M.D.; Thomas A. McKell, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; (Absent — Richard G. Connar, M.D.; Ralph E. Rydell, M.D.; H. Stewart Siddall, M.D.; Harold L. Williamson, M.D.; Mr. T. Roland Reeves, Student)

INDIAN RIVER — Donald AMes, M.D.; David Griffin, M.D.; Kip G. Kelso, M.D.

LAKE — Joseph E. Holland Jr., M.D.; Robert H. Hux, M.D.; (Absent — Joseph A. Comfort, M.D.)

LEE — Robert J. Brueck, M.D.; Larry P. Garrett, M.D.; F. Lee Howington, M.D.; H. Quillian Jones Jr., M.D.; Douglas A. Newland, M.D.; (Absent — Joseph P. Fiore, M.D.)

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D.; (Absent — William A. Boyce, M.D.; Robert A. Fasoli, M.D.; Julian Giraldo, M.D.; Roger A. Meyer, M.D.)

MARION — Claude B. Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D.; (Absent — James M. Hayes, M.D.)

MONROE — (Absent — Ronald H. Chase, M.D.)

NASSAU — (Absent — Robert L. Taylor, M.D.)

OKALOOSA — William W. Thompson, M.D.; (Absent — David R. Arrowsmith, M.D.)

ORANGE — Francis M. Coy, M.D.; Wayne L. Godbold, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Thomas Scott, M.D.; Robert N. Serros, M.D.; Cecil B. Wilson, M.D.; (Absent — Edward Ackerman, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; David L. Mackey, M.D.; Calvin R. Peters, M.D.; Wallace M. Philips Jr., M.D.; Philip N. Styne, M.D.; T. Byron Thames, M.D.)

OSCEOLA — John R. Hartman, M.D.; Alonzo J. Logan, M.D.

PALM BEACH — E. Joan Barice, M.D.; Richard C. Cavanagh, M.D.; McKinley Cheshire, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; R. Benjamin Moore, M.D.; Gilbert R. Panzer, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; (Absent — Vernon B. Astler, M.D.; Robert Burger, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; William J. Romanos Jr., M.D.; Joel F. Smith, M.D.; Ben R. Thebaut Jr., M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Carl W. Graves, M.D.; Maynard F. Taylor, M.D.; (Absent — Vincent G. Cotroneo, M.D.)

PINELLAS — William W. Atkinson, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony P. Garritano, M.D.; William E. Hale, M.D.; John Hamilton, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris LeVine, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Howard L. Reese, M.D.; William H. Schmid, M.D.; Bruce P. Smith, M.D.; Walter H. Winchester, M.D.; (Absent — Thomas M. Daniel, M.D.; Jack MaCris, M.D.)

POLK — Francis D. Drake, M.D.; Richard M. Garcia, M.D.; John W. Glotfelty, M.D.;Thomas E. McMicken, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; Daniel W. Welch, M.D.; (Absent — Ronald W. Case, M.D.)

PUTNAM — Patrick J. O'Malley, M.D.

ST. LUCIE-OKEECHOBEE — Khalil A. Cassimally, M.D.; (Absent — David L. Fromang, M.D.; Manuel G. Garcia, M.D.)

SANTA ROSA — David B. Young, M.D.

SARASOTA — Jack E. Baron, M.D.; William E. Bush, M.D.; John N. Carlson, M.D.; Robert W. Dein, M.D.; Kenneth C. Kiehl, M.D.; Frank H. Pfeiffenberger, M.D.; Karl R. Rolls, M.D.; Ernest C. Smith Jr., M.D.; (Absent — David L. Thomas, M.D.)

SEMINOLE — Maria P. Perez, M.D.; (Absent — Humberto A. Dominguez, M.D.; Orlando Garcia-Piedra, M.D.)

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — John H. Parker, M.D.

VOLUSIA — Harry F. Farmer, M.D.; Richard H. Huster, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.; H.S. Budd Treloar, M.D.

WALTON — (Absent — James G. Leker, M.D.)

WASHINGTON — (Absent — Muhammad I. Zafar, M.D.)

SPEAKER OF THE HOUSE — Guy T. Selander, M.D.

VICE-SPEAKER — Arthur L. Eberly Jr., M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

SPECIALTY GROUPS — Michael Alberts, M.D.; Paul H. Bridgeford, M.D.; Richard Chidsey, M.D.; George A. Gant, M.D.; Ira Gessner, M.D.; David A. Giordano, M.D.; Mutaz Habal, M.D.; Jerry L. Harris, M.D.; Robert Hoover, M.D.; T. T. Knight, M.D.; Donald S. Kwalick, M.D.; Clifford Lober, M.D.; Jimmie D. Moore, M.D.; Rasheed T. Myint, M.D.; Arthur Pearl, M.D.; Sylvan H. Sarasohn, M.D.; Daniel J. Schwartz, M.D.; Daniel J. Sprehe, M.D.; Malvin Weinberger, M.D.

Dr. Eberly introduced Yank D. Coble Jr., M.D., FMA Treasurer and Mrs. Susan Marks, President-Elect, FMA Auxiliary.

Report of Reference Committee No. I Legislation and Miscellaneous

Dr. Selander called the Chairman and members of Reference Committee No. I, Legislation and Miscellaneous to present the Report.

Lee A. Fischer, M.D., Chairman and his Committee came forward to present the Report of Reference Committee No. I, Legislation and Miscellaneous.

Report of the Board of Governors

Recommendation No. 1 was amended by deleting lines 25-30 and substituting "Support in 1986 development and passage of legislation which provides for resolving medical malpractice claims through a system which brings about resolution of such claims outside the current civil litigation process." Recommendation No. 1 was adopted as amended.

Recommendation No. 2 was amended so that lines 58-60 read "That Section 458.315 not be sunset, but be amended to require that the local county health officers certify the need and be responsible for any abuse of a temporary certificate."

Lines 36-97 were adopted as corrected and amended.

Lines 98-103 were amended by substituting

1. 'Resolved, That the Florida Medical Association modify its present policy of opposition to efforts to authorize the practice of physical therapy without the prescription of a physician licensed under Chapter 458, 459, or a dentist licensed under Chapter 466. Chapter 486, Florida Statutes, the Physical Therapy Practice Act, be further amended to require that a physician of record be identified for each physical therapy patient, and that the physician of record be responsible for approving, disapproving or modifying a treatment plan developed by the physical therapist.
2. Resolved, That the Florida Medical Association support the concept that physicians who own physical therapy services or employ physical therapists should in all cases offer patients freedom of choice by advising them of the availability of other physical therapy services.
3. Resolved, That the Florida Medical Association actively oppose any and all legislative efforts to prohibit physicians from employing physical therapists, nurses, or any other licensed or registered health care provider.'''

The motion of the Reference Committee to adopt the substitution for lines 98-103 carried.

Lines 105-110 were amended by substituting "Oppose the independent practice of medicine by the nursing profession, nurse anesthetists, and lay midwifery."

Lines 111-116, page 1, and lines 1-11, page 2, were adopted as presented.

Lines 12-20, page 2, the Committee felt that adoption of the Board's recommendation would also encompass the intent of Resolution 86-11. The Committee agreed with the Board's recommendation and recommended its adoption. The recommendation of the Reference Committee to adopt lines 12-20 passed. The recommendation of the Reference Committee that Resolution 86-11 be not adopted passed. The recommendation of the Reference Committee that Resolution 86-20 be not adopted passed.

The recommendation of the Reference Committee to approve lines 23-26 and recommend that the FMA work to delete from HB1003, page 4, lines 13

through 15 after the word "facilities" in line 13 passed.

Lines 28-76, page 2, were adopted as presented.

The recommendation of the Reference Committee to substitute for lines 77 through 83, page 2, "Continue to oppose entrepreneural entities from decreasing the quality of care, limiting access to health care, limiting free and independent practice, and controlling professional fees" passed.

The recommendation of the Reference Committee that lines 85-134 be filed passed.

The recommendation of the Reference Committee to add "Allied Health Professions — Dentistry, Oppose dentists administering anesthesia in non-dental procedures" to Recommendation No. 2 passed.

Report of the Board of Governors

Luis M. Perez, M.D., Chairman

Recommendations Regarding the Association's Legislative Program for 1986

RECOMMENDATIONS

RECOMMENDATION NO. 1

THAT THE FLORIDA MEDICAL ASSOCIATION HOUSE OF DELEGATES APPROVE THE FOLLOWING AS THE ASSOCIATION'S LEGISLATIVE PROGRAM FOR 1986 IN RESPECT TO PROFESSIONAL LIABILITY:

SUPPORT PLACING A CAP ON GENERAL DAMAGES (NON-ECONOMIC);

SUPPORT THE ELIMINATION OF THE DOCTRINE OF JOINT AND SEVERAL LIABILITY;

CONTINUE TO OPPOSE THE REQUIREMENT OF PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AS A CONDITION OF LICENSURE;

SUPPORT IN 1986 DEVELOPMENT AND PASSAGE OF LEGISLATION WHICH PROVIDES FOR RESOLVING MEDICAL MALPRACTICE CLAIMS THROUGH A SYSTEM WHICH BRINGS ABOUT RESOLUTION OF SUCH CLAIMS OUTSIDE THE CURRENT CIVIL LITIGATION PROCESS.

EVALUATE THE FEASIBILITY OF A CONSTITUTIONAL AMENDMENT CAMPAIGN FOR 1988 AS A MEANS OF RESOLVING THE PROFESSIONAL LIABILITY CRISIS.

RECOMMENDATION NO. 2

THAT THE FLORIDA MEDICAL ASSOCIATION HOUSE OF DELEGATES APPROVE THE FOLLOWING AS THE ASSOCIATION'S LEGISLATIVE PROGRAM IN RESPECT TO NON-PROFESSIONAL LIABILITY ISSUES:

MEDICAL PRACTICE ACT

DELETE THE WORD "SOLE" IN SECTION 458.301, FLORIDA STATUTES, AND INSERT THE WORDS "AND EFFECTIVE" AFTER THE WORD "SAFE".

DELETE "AND WHO ARE NOT CONNECTED IN ANY WAY WITH ANY MEDICAL COLLEGE" FROM SECTION 458.307(2), FLORIDA STATUTES.

SUNSET SECTION 458.313(2), PARTS OF SECTION 458.313(2)(a), AND SECTION 458.313(b), THAT CREATES SPECIAL LICENSURE EXEMPTIONS FOR PHYSICIANS TO PRACTICE IN THE STATE OF FLORIDA.

THAT SECTION 458.315 NOT BE SUNSET, BUT BE AMENDED TO REQUIRE THAT THE LOCAL COUNTY HEALTH OFFICERS CERTIFY THE NEED AND BE RESPONSIBLE FOR ANY ABUSE OF A TEMPORARY CERTIFICATE.

SUNSET SECTION 458.322, FLORIDA STATUTES, WHICH REQUIRES THE DPR TO ASK FOR AND KEEP RECORDS FOR WHETHER A PHYSICIAN ACCEPTS MEDICARE ASSIGNMENTS.

CREATION OF A NEW SUBSECTION OF SECTION 458.331, FLORIDA STATUTES, WHICH WOULD PROVIDE FOR APPROPRIATE DISCIPLINE FOR ANY PHYSICIAN WHO GIVES FALSE OR SUBSTANDARD OR UNPROFESSIONAL EXPERT WITNESS TESTIMONY, EITHER BY AFFIDAVIT, DEPOSITION OR COURTROOM TESTIMONY.

SUNSET SECTION 458.333, FLORIDA STATUTES, AND 458.335, FLORIDA STATUTES, IN RESPECT TO LAETRILE AND DMSO.

AMEND SECTION 458.337, FLORIDA STATUTES, WHICH WOULD ADD GOVERNMENTAL AGENCIES TO THE LIST OF THOSE THAT ARE REQUIRED TO REPORT DISCIPLINARY ACTIONS AGAINST PHYSICIANS TO THE DPR.

AMEND SECTION 458.345, FLORIDA STATUTES, WHICH WOULD CHANGE THE REPORTING REQUIREMENTS FOR HOSPITALS EMPLOYING A RESIDENT PHYSICIAN, ASSISTANT RESIDENT PHYSICIAN, HOUSE PHYSICIAN OR INTERN FROM TWICE A YEAR TO ONCE A YEAR AND FOR EACH HOSPITAL TO SUBMIT AN AMENDMENT TO THE DPR UPON EMPLOYMENT OF A NEW PHYSICIAN OR PHYSICIANS DURING THE INTERIM PERIOD.

ALLIED HEALTH PROFESSIONS - CHIROPRACTIC

OPPOSE EFFORTS TO EXPAND THE SCOPE OF CHIROPRACTIC PRACTICE.

ALLIED HEALTH PROFESSIONS - PHYSICAL THERAPY

1. "RESOLVED, THAT THE FLORIDA MEDICAL ASSOCIATION MODIFY ITS PRESENT POLICY OF OPPOSITION TO EFFORTS TO AUTHORIZE THE PRACTICE OF PHYSICAL THERAPY WITHOUT THE PRESCRIPTION OF A PHYSICIAN LICENSED UNDER CHAPTER 458, 459, OR A DENTIST LICENSED UNDER CHAPTER 466. CHAPTER 486, FLORIDA STATUTES, THE PHYSICAL THERAPY PRACTICE ACT, BE FURTHER AMENDED TO REQUIRE THAT A PHYSICIAN OF RECORD BE IDENTIFIED FOR EACH PHYSICAL THERAPY PATIENT, AND THAT THE

PHYSICIAN OF RECORD BE RESPONSIBLE FOR APPROVING, DISAPPROVING OR MODIFYING A TREATMENT PLAN DEVELOPED BY THE PHYSICAL THERAPIST.

2. RESOLVED, THAT THE FLORIDA MEDICAL ASSOCIATION SUPPORT THE CONCEPT THAT PHYSICIANS WHO OWN PHYSICAL THERAPY SERVICES OR EMPLOY PHYSICAL THERAPISTS SHOULD IN ALL CASES OFFER PATIENTS FREEDOM OF CHOICE BY ADVISING THEM OF THE AVAILABILITY OF OTHER PHYSICAL THERAPY SERVICES.
3. RESOLVED, THAT THE FLORIDA MEDICAL ASSOCIATION ACTIVELY OPPOSE ANY AND ALL LEGISLATIVE EFFORTS TO PROHIBIT PHYSICIANS FROM EMPLOYING PHYSICAL THERAPISTS, NURSES, OR ANY OTHER LICENSED OR REGISTERED HEALTH CARE PROVIDER."

ALLIED HEALTH PROFESSIONS - NURSING

OPPOSE THE INDEPENDENT PRACTICE OF MEDICINE BY THE NURSING PROFESSION, NURSE ANESTHETISTS AND LAY MIDWIFERY.





Reference Committee No. I (Legislation and Miscellaneous). (A) Left to right: Harold G. Norman, M.D., Coral Gables (not pictured); Theodore W. Hahn, M.D., Pompano Beach; Mrs. Dawn Gerik, Recorder; Lee A. Fischer, M.D., Chairman, West Palm Beach. (B) Left to right: Charles T. Montgomery, M.D., Jacksonville (not pictured); H. Quillian Jones Jr., M.D., Fort Myers; Glenn S. Hooper, M.D., Tampa; Eric F. Geiger, M.D., Pensacola; Robert N. Serros, M.D., Orlando; David A. Giordano, M.D., Sarasota.

ALLIED HEALTH PROFESSIONS - PHARMACY

OPPOSE EFFORTS TO EXPAND THE LAW THAT AUTHORIZES PHARMACISTS TO PRESCRIBE CERTAIN DRUGS.

SEEK TO AMEND SECTION 465.186(5), FLORIDA STATUTES, TO UPGRADE VIOLATIONS OF SECTION 465.186, FLORIDA STATUTES, FROM A FIRST DEGREE MISDEMEANOR TO A MORE SERIOUS OFFENSE.

ALLIED HEALTH PROFESSIONS - OPTOMETRY

OPPOSE EFFORTS BY THE OPTOMETRISTS SEEKING AUTHORITY TO USE CERTAIN DRUGS IN THE PRACTICE OF OPTOMETRY.

ALLIED HEALTH PROFESSIONS - DENTISTRY

OPPOSE DENTISTS ADMINISTERING ANESTHESIA IN NON-DENTAL PROCEDURES.

CERTIFICATE OF NEED

SEEK ABOLISHMENT OF THE CERTIFICATE OF NEED PROGRAM, EITHER IMMEDIATELY OR BY PHASE-OUT, PROVIDED THAT IN THE EVENT THE CERTIFICATE OF NEED IS RETAINED BY THE LEGISLATURE, THERE BE NO EXPANSION OF THE CURRENT CERTIFICATE OF NEED PROGRAM INTO PHYSICIANS' OFFICES.

TRAUMA CENTERS

SUPPORT THE TRAUMA CENTER LEGISLATION SIMILAR TO COMMITTEE SUBSTITUTE FOR HOUSE BILL 1003 WITH APPROPRIATE FUNDING SOURCES TO BE DEVELOPED.

INDIGENT HEALTH CARE

SEEK THROUGH LEGISLATIVE MEANS ADEQUATE FUNDING OF INDIGENT AND MEDICALLY INDIGENT HEALTH CARE THROUGH A BROAD-BASED REVENUE FUNDING SOURCE OR SOURCES; AND FURTHER THAT SERVICES PROVIDED TO THE INDIGENT AND MEDICALLY INDIGENT BE DELIVERED THROUGH A COORDINATED PUBLIC AND PRIVATE SECTOR PROVIDER SYSTEM THAT INCLUDES INDEPENDENT PRACTITIONERS WITH EMPHASIS ON PRIMARY CARE AND PREVENTIVE MEDICINE.

REORGANIZATION OF THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

SEEK THROUGH LEGISLATIVE MEANS, AS CALLED FOR IN HOUSE BILL 1427, THE REINTRODUCTION OF THE POSITION OF STATE HEALTH OFFICER INTO THE FLORIDA STATUTES WITH THE QUALIFICATIONS, AUTHORITIES, AND RESPONSIBILITIES TO BE CLEARLY DEFINED BY THE STATUTE: THAT THE STATE HEALTH OFFICER BE A PHYSICIAN LICENSED UNDER CHAPTER 458 OR 459 WITH DIRECT LINE AUTHORITY OVER THE STATEWIDE PUBLIC HEALTH SYSTEM, INCLUDING ALL HEALTH AND HEALTH-RELATED SERVICES, PROGRAMS, AND STATUTORY RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES AND THOSE CURRENTLY IN SUCH OTHER AGENCIES OF THE STATE GOVERNMENT AS MAY BE APPROPRIATE: THAT THE POSITION OF STATE HEALTH OFFICER BE PLACED AT AN ORGANIZATION LEVEL WITHIN FLORIDA STATE GOVERN-

MENT WITH ADEQUATE PROFESSIONAL SUPPORT STAFF AND FUNDING TO CARRY OUT WITH UNDUPLICATED AUTHORITY THE PUBLIC HEALTH LAWS OF THIS STATE; AND FURTHER THAT THE DELINEATION AND LEVEL OF AUTHORITY, WHEN DETERMINED, BE BROUGHT BACK TO THE BOARD OF GOVERNORS FOR FINAL APPROVAL.

FOREIGN MEDICAL GRADUATES

DEVELOP LEGISLATIVE SUPPORT IN COORDINATION WITH THE DEPARTMENT OF PROFESSIONAL REGULATION FOR A PROPOSAL TO ENSURE THAT ALL INDIVIDUALS APPLYING FOR AND TAKING THE MEDICAL LICENSURE EXAMINATION IN FLORIDA HAVE MET THE SAME EDUCATIONAL STANDARDS AND TRAINING REQUIREMENTS NECESSARY TO PRACTICE MEDICINE IN THE STATE.

ENCROACHMENT ON THE PRACTICE OF MEDICINE

CONTINUE TO OPPOSE ENTREPRENEURAL ENTITIES FROM DECREASING THE QUALITY OF CARE, LIMITING ACCESS TO HEALTH CARE, LIMITING FREE AND INDEPENDENT PRACTICE, AND CONTROLLING PROFESSIONAL FEES.

Overview - Status of Professional Liability 1986

As we move into 1986, the professional liability problem continues to rage at crisis proportions in Florida and across the United States. Dramatic and continuing increases in the frequency and severity of suits, awards and settlements continue to drive the crisis. Past efforts to revise and balance the tort system, while laudatory, have proven unsuccessful in stemming the tide of the increasing number of cases and the cost of those cases. As we begin 1986, the crisis again has been underlined by the recently announced increase in premiums for subscribers of the Florida Physicians' Insurance Reciprocal, the FMA-sponsored professional liability insurer. Similar increases are expected to be announced by other major Florida insurers in the coming months.

Numerous incidents of physicians leaving practice, retiring early or reducing their scope of practice continue to be reported across the state.

During the last year, the liability problems that have plagued physicians for over a decade have begun to adversely affect other professions and many businesses and industries. Indeed, the professional liability crisis has now become a liability crisis of universal proportions.

As we move into 1986, the Florida Medical Association Board of Governors believes without reservation that this issue continues to be the number one priority of the Association and that maximum efforts and resources must be utilized in resolving the crisis. During the last ten years the Association has sought to take the message of the worsening crisis in professional liability to the public, the media and the legislature. While we have achieved some successes, we know the problem has not been solved. However, we firmly believe that we are on the brink of success and that with a unified effort involving every member of this Association, we can prevail. The health and welfare of our patients deserves no less than a maximum committed effort by each member of the Association.

1985 Legislative Session

The 1985 Legislature passed a professional liability bill entitled, "The 1985 Comprehensive Medical Malpractice Act".

This bill originated in the Medical Malpractice Subcommittee of the House Health and Insurance Committee. These committees received extensive input from the insurance industry, hospitals, trial lawyers and, of course, the medical profession. While the bill does not offer a complete solution to the problem, there were significant provisions in the bill that will have, in time, a real effect on resolving the medical malpractice problem. Major positive changes contained in the final law are:

1. Structured settlements are mandatory, upon the request of either party, for future damages (both general and special);
2. Community standard of care is established and expert witnesses must have been in the active practice or teaching of medicine within the previous five years;
3. Sliding scale for attorney fees with a maximum of 15% allowed on any award over $2 million;
4. A new offer of judgment statute which would encourage settlement;
5. A 90-day cooling off statute, coupled with nonbinding arbitration, when appropriate, which should help resolve cases without lengthy and expensive trials;
6. Increased protection for peer review committees.

The Legislature failed to come to grips with the issue of limitations on general damages or an alternative resolution system. Additionally, the bill contained a requirement for professional liability insurance for M.D.s and osteopaths at the level of $250,000/$750,000 as a condition for hospital staff privileges and $100,000/$300,000 for those without hospital staff privileges. This provision becomes effective on January 1, 1987. This report contains a recommendation in respect to dealing with this issue during the 1986 legislative session.

While the passage of the malpractice act did not go far enough to resolve the problem, it did constitute a recognition by the Legislature that the malpractice crisis in Florida is indeed real and a threat to quality health care for the citizens of this state. The Legislature, for the first time in ten years, took an in-depth look at the crisis and enacted legislation which we feel will provide some relief and form the foundation for further remedies to be pursued in 1986.

Post-1985 Legislative Activities (Professional Liability)

A. Council on Legislation

At its Post-1985 Legislative Session Board Meeting, the Board of Governors requested the Council on Legislation to review the professional liability issue in depth and formulate a recommended policy for 1986 and beyond. The Council on Legislation assembled several well-known experts in law, economics and insurance. The consensus of the experts was that any resolution of the crisis must address a limitation or elimination of general damages and consideration of a long-term solution should include an alternative resolution system to take the place of the current inefficient tort system. The Council on Legislation met on August 16, 1985, and September 21, 1985, and formulated its recommendations after hearing presentations by the panel of experts who expressed their respective opinions on how to effectively approach the professional liability problem. These recommendations were acted on by the Board of Governors at its October meeting and constitute the Board's recommendations to the House for continuing the Association's quest for a solution to the professional liability dilemma.

The issue of professional liability has been comprehensively discussed and the objectives arrived at in an analytical manner, both at the council and board level.

B. Legislative Leadership

The President and President-Elect, along with others,

have met with the key leadership of the House and Senate, as well as presenting the Association's concerns to the Insurance Commissioner. It is the opinion of our leadership that the Speaker of the House and the President of the Senate are not at this point in time willing to take an aggressive role in resolving the crisis. The Speaker of the House expressed his feeling that the 1985 bill ought to be given time to work and would only be willing to address the malpractice problem in-depth if enough members of the House requested that he do so. The President of the Senate has indicated that he is willing to continue to review the issue and would be looking to his key leadership in the Senate to determine what, if anything, needs to be done during the 1986 session. The Insurance Commissioner has indicated a willingness to continue to pursue efforts to resolve the crisis and has recognized that this issue is of critical importance to the health care of the citizens of Florida.

C. Coalition Building

During the last several months of 1985 and into 1986, the President and Officers of the Florida Medical Association have visited with many representatives of other organizations who are being affected by the overall liability crisis. It is the feeling of the Board and legislative consultants that, in order to achieve a final and lasting resolution to this issue, we must form a strong coalition in an effort to create solutions that affect the entire tort system. Accordingly, a formalized statewide coalition is in the process of being organized by the Florida medical Association with the intent that this coalition will work toward appropriate and lasting solutions through the legislative process or through a constitutional initiative, if necessary.

Post-1985 Legislative Activities (Non-Professional Liability)

The Board recommendations regarding non-professional liability legislative issues reflects the input and deliberation of many FMA councils and committees and were submitted through the Council on Legislation and then on to the Board of Governors for consideration and recommendation to the House of Delegates. Each of the councils and committees worked extensively and expended a great deal of time and effort in providing the Council on Legislation with its early development of recommendations. The input from the various councils and committees on the issues outlined and described in this report have been assimilated and fact sheets on each of these issues will be included in the delegate's packet to be distributed at the time of the Interim Meeting.

RESOLUTION 86-1
Constitutional Revision Re: Limits on Contingency Fees
Dade County Medical Association

Resolution 86-1 was not adopted.

RESOLUTION 86-2
Constitutional Revision Re: PLI
Dade County Medical Association

Resolution 86-2 was not adopted.

RESOLUTION 86-3
Foreign Medical School Graduates
Dade County Medical Association

The motion of the Reference Committee that the first Resolved of Resolution 86-3, lines 7 through 10 be deleted and that line 12 be amended by adding the words "students or" after the word "medical" passed. Resolution 86-3 was adopted as amended.

RESOLUTION 86-3

Foreign Medical School Graduates

Dade County Medical Association

RESOLVED, That the Florida Medical Association coordinate with the State Board of Medical Examiners the necessary strategy to eliminate the licensure of physicians who present themselves as graduates of non-accredited foreign medical schools, and be it further

RESOLVED, That the Florida Medical Association promote the elimination of externship programs which train foreign medical students or graduates as a part of a rotation teaching program.

RESOLUTION 86-4
Professional Liability Insurance Premiums
Dade County Medical Association

The motion that Resolution 86-4 be referred to the Board of Governors carried.

RESOLUTION 86-4

Professional Liability Insurance Premiums

(Referred to Board of Governors)

Whereas, The State Law HB 1352 mandates professional liability insurance be carried by all physicians in the State of Florida commencing January 1, 1987; and

Whereas, The State Legislature has not provided for any controlling mechanism of professional liability premiums; therefore be it

RESOLVED, That the Florida Medical Association petition the State Legislature to: a) cap the premiums for mandatory professional liability insurance; b) establish a state regulatory board for the purpose of controlling these premiums, and c) request the creation of a Governor's Committee for such a purpose.

RESOLUTION 86-5
Mandatory Professional Liability Insurance
Dade County Medical Association

The Reference Committee discussed this resolution at length and received information on how FMA sets its legislative priorities. There are essentially no categories for priorities except to oppose or support. The Reference Committee believed the clear intent of the House was to give this issue high priority utilizing the maximum legislative resources of the Association. It believed that our opposition should be toward mandatory professional liability insurance as a condition of licensure. The Committee offered a substitute resolultion. The adoption of

Substitute Resolution 86-5 was moved, the motion was carried and Substitute Resolution 86-5 was adopted.

SUBSTITUTE RESOLUTION 86-5

Mandatory Professional Liability Insurance

RESOLVED, That the FMA give high priority to repeal mandatory professional liability insurance as a condition of licensure.

RESOLUTION 86-6
Alternative Delivery System Licensure
Broward County Medical Association

The motion that Resolution 86-6 be referred to the Board of Governors carried.

RESOLUTION 86-6

Alternative Delivery System Licensure

(Referred to Board of Governors)

Whereas, Treatment, hospital admission, consultation and other obviously medical options are being determined by less trained disciplines under the guise of alternative delivery systems, and

Whereas, This type of impersonal contact is nevertheless a rendition of diagnosis or treatment, it is

RESOLVED, That the practice of medicine is permitted by license of the Division of Professional Regulation, and that the practice of medicine by HMO, PPO, EPO, or other alternative delivery system should be under the licensure provisions of the Division of Professional Regulation.

RESOLUTION 86-7
Mandatory Insurance — Prerequisite to Licensure
Broward County Medical Association

The motion that Resolution 86-7 be referred to the Board of Governors carried.

RESOLUTION 86-7

Mandatory Insurance — Prerequisite to Licensure

(Referred to Board of Governors)

RESOLVED, That the Florida Medical Association seek legal redress questioning the constitutionality of the mandatory insurance provisions as a prerequisite to licensure of the practice of medicine in the State of Florida.

RESOLUTION 86-8
Contingency Patient Compensation Law
Dade County Medical Association

The motion that Resolution 86-8 be referred to the Board of Governors carried.

RESOLUTION 86-8

Contingency Patient Compensation Law

(Referred to Board of Governors)

Whereas, The cost for professional liability insurance is creating a so-called "malpractice crisis"; and

Whereas, The main reason for carrying professional liability insurance is to provide protection for economic losses of patients who may be injured during the course of treatment, including surgery; and

Whereas, It has been estimated that only about 28 cents out of every dollar paid in premiums really get to the injured patient and about 60 cents go for legal fees; and

Whereas, Awards made by juries are intended to compensate primarily the injured patients and not the legal profession; and

Whereas, It is the duty of the Florida Medical Association to see that injured patients are properly compensated for results of malpractice (not maloccurrences) on the part of Florida physicians; therefore be it

RESOLVED, that the Florida Medical Association add to its legislative goals that of promoting a law to guarantee a "contingency patient compensation" for injured patients who win jury awards, based on a graduated scale which will channel most of the award to the plaintiff such as follows:

(A) If the award is $50,000.00 or less — 60% should go to the injured patient.
(B) If the award is greater than (A), 67% of any amount from $50,000.00 to $100,000.00 should go to the injured patient.
(C) If the award is greater than (B), 75% of any amount from $100,000.00 to $200,000.00 should go to the injured patient.
(D) If the award is over $200,000.00, 90% of any amount over this should go to the injured patient.
(E) It is understood that all legal costs will be treated as has been the custom previously.

RESOLUTION 86-9
Pharmaceutical Samples
Dade County Medical Association

Resolution 86-9 was adopted.

RESOLUTION 86-9

Pharmaceutical Samples

RESOLVED, That the FMA actively and aggressively oppose enactment of any legislation to limt or prohibit the use of sample medications by Florida physicians.

RESOLUTION 86-17
All-Terrain Motor Driven Vehicles
Lee County Medical Society

The motion of the Reference Committee that the name of the Resolution be changed to "All-Terrain Motor Driven Vehicles," and the deletion of line 9 and re-lettering the four remaining sections, A, B, C, D, carried. The motion of the Reference Committee that Resolution 86-17 be adopted as amended carried.

RESOLUTION 86-17

All-Terrain Motor Driven Vehicles

RESOLVED, That the FMA lobby the State Legislature to enact legislation concerning all-terrain motor driven vehicles that shall require the following:

a) Helmets on drivers at any time the vehicle is in motion.
b) A valid Florida drivers license for driver of vehicle.
c) Mandatory drivers education and competency course completion before receiving a specific license for operation of these vehicles.
d) Licensing of all-terrain vehicle (motor-driven).

RESOLUTION 86-18
Professional Liability Registry
Palm Beach County Medical Society

The motion that Resolution 86-18 be referred to the Board of Governors carried

RESOLUTION 86-18

Professional Liability Registry

(Referred to Board of Governors)

Whereas, There are no exact state-wide figures on the number of professional liability suits filed in Florida and their eventual disposition; and

Whereas, The public does not hear about the large number of baseless suits that are filed and either dropped or eventually won by the doctor, therefore be it

RESOLVED, That the Florida Medical Association work to enact a law requiring that all professional liability suits filed in Florida be registered with the Department of Insurance and as a matter of public record, and that such registration contain the following information: name and address of plaintiffs and defendants, name and address of plaintiffs' attorneys and the final disposition of the suit (dropped, settled, trial with jury verdict, etc.).

The Reference Committee expressed its appreciation to all members of the Association who appeared at their meeting.

The Chairman expressed his sincere appreciation to members of the Committee: Doctors Eric F. Geiger, Charles T. Montgomery, Glenn S. Hooper, David A Giordano, H. Quillian Jones Jr., Robert N. Serros, Theodore W. Hahn, and Harold G. Norman.

The Reference Committee also expressed its deepest appreciation to FMA staff, George S. Palmer Jr., and Mrs. Dawn Gerik for their assistance in preparing this report.

The motion of the Reference Committee that the Report of Reference Committee No. 1, Legislation and Miscellaneous, be adopted as amended carried.

The Speaker, Dr. Selander, announced the results of the elections as they occurred on Saturday, January 25, 1986 as follows:

AMA Delegate Seat #12 — J. Lee Dockery, M.D.
AMA Alternate Seat #12 — Henry M. Yonge, M.D.
AMA Alternate Seat #8 — Alvin E. Smith, M.D.

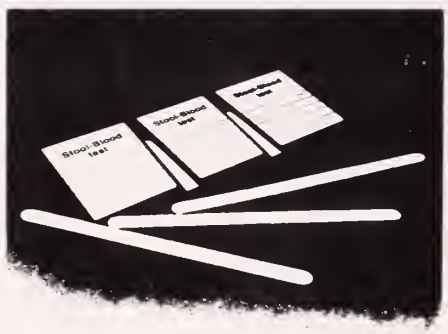
The new terms for Delegate Seat 12 and Alternate Delegate Seats 8 and 12 are for two years beginning January 1, 1986, and expiring December 31, 1987.

Dr. Selander announced that the FMA Annual Meeting will be held September 17 through 20, 1986 at the Diplomat Hotel in Hollywood, Florida

Dr. Selander then called Arthur L. Eberly Jr., M.D., to the podium for the benediction.

The 1986 Interim Meeting of the House of Delegates adjourned at 9:40 a.m.

50,000 people will be saved from colorectal cancer this year. You can save one.



Save yourself! Colorectal cancer is the second leading cause of cancer deaths after lung cancer. More than 90% of colorectal cancers occur equally in men and women past age 50. Early detection provides the best hope of cure. That's why if you're over 50, you should take this simple, easy Stool Blood Test every year. The test kit is chemically treated to detect hidden blood in the stool and can be done at the time of your periodic health examination so your doctor will know the results.

Two days before the test, you begin a diet you might enjoy all the time. Plenty of fresh vegetables raw or cooked, especially corn, spinach and lettuce. Lots of plums, grapes, apples and prunes, moderate amounts of peanuts and popcorn. No red meat, turnips or horseradish. Do's and don't's are listed in the kit.

The presence of hidden blood usually indicates some problem in the stomach or bowel, not necessarily cancer. Positive tests must be followed by further testing to find out what the problem is.

Other tests for colorectal cancer you should talk to your doctor about: Digital rectal exam (after age 40); the procto test (after age 50). It is important to report any personal or family history of intestinal polyps or ulcerative colitis, and any change in your bowel habits, which could be a cancer warning signal.

The American Cancer Society wants you to know.



AMERICAN CANCER SOCIETY®

University of Miami
School of Medicine
Department of Medicine

REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE

May 12-16, 1986

Key Biscayne Hotel & Villas
Key Biscayne, Florida

A course especially designed for physicians who are preparing for board certification or recertification in Internal Medicine.

State of the Art Lectures

—

Meet the Faculty Sessions

—

Patient Management Problem Sessions

—

Audiovisual Aids

—

Self-assessment Questionnaire Sessions

—

Pictorial Quizzes • Printed Materials

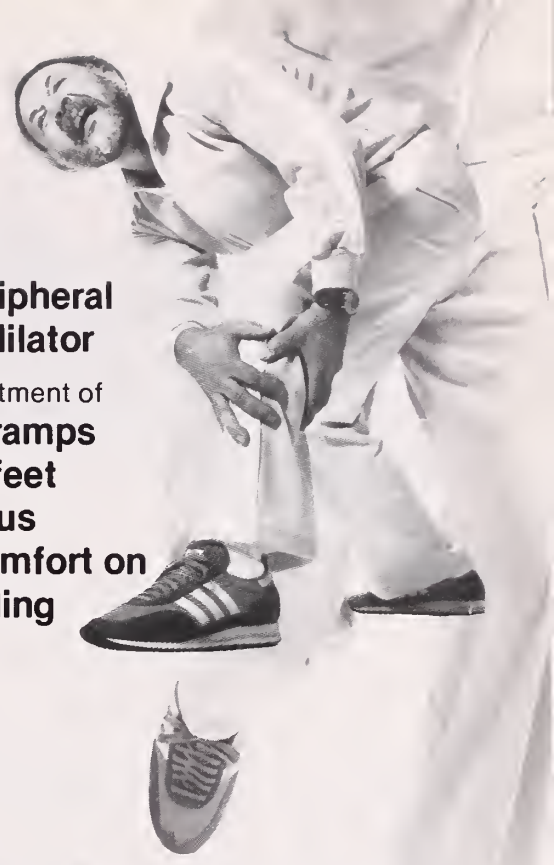
—

39.5 Hours of AMA Category I Credit

Registration: $325 (before March 30, 1986)
$350 (after March 30, 1986)

For registration and information write to:

J. Bocles, M.D., Department of Medicine (R760), University of Miami School of Medicine, P.O. Box 016760, Miami, Florida 33101. Phone: (305) 547-6063.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy



For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.



Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.



Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.



Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

FAMILY PHYSICIANS—GENERAL SURGEONS—INTERNISTS

Why, How and When?

flexible sigmoidoscopy

A 1½ day post graduate course and workshop

- *ACCREDITATION:* Approved for 10½ hrs. credit; Category 1, AMA, and Prescribed credit, AAFP.
- *SPONSOR:* Medical Education Foundation of Miami
- *CO-SPONSORS:* South Miami Hospital, Florida Gastroenterologic Society
- *COURSE DIRECTOR:* John P. Christie, M.D.
- *REGISTRATION FEE:* $225.00 (Syllabus and luncheon included)

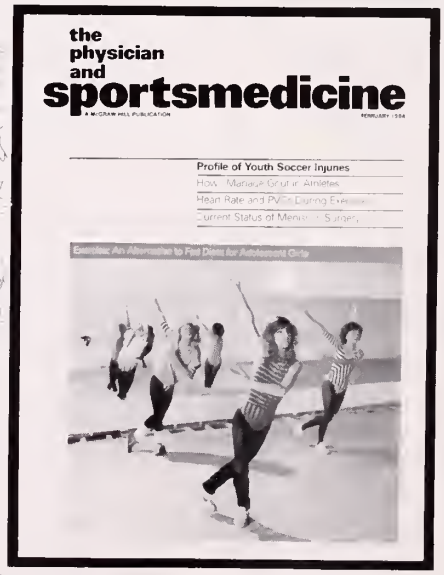
Sat./Sun., Apr. 19-20, or Nov. 15-16, 1986

Sonesta Beach Hotel and Tennis Club

For information, write to:
6614 Miami Lakes Drive East
Miami Lakes, Florida
(305) 687-1367

OVER 66,000 FAMILY PHYSICIANS READ THIS JOURNAL





Practical information on the medical aspects of fitness and exercise.

Tennis elbow: Joint resolution by conservative treatment.

Hypertrophic cardiomyopathy and the athlete.

Effects of sunscreen use during exercise in the heat.

Overuse injuries to the knee in runners.

How I manage ingrown toenails.

The elements of power

"In passing by the side of Mount Thai, Confucius came on a woman who was weeping bitterly by a grave. The Master pressed forward and drove quickly to her; then he sent Tze-Lul to question her. 'Your wailing,' said he, 'is that of one who has suffered sorrow on sorrow.' She replied, 'That is so. Once my husband's father was killed here by a tiger. My husband was also killed, and now my son has died in the same way.' The Master said, 'Why do you not leave the place?' The answer was, 'There is no oppressive government here.' The Master then said, 'Remember this, my children; oppressive government is more terrible than tigers.'"

Physicians are feeling kinship with the oppressed. This paranoia is perhaps appropriate and not hyperbolic. The federal government has singled out the medical profession for an interminable fee freeze. The government of Massachusetts has repealed the law of supply and demand for the medical profession by imposing assignment and the Blue Cross/Blue Shield fee schedule on all physicians and by denying the right of the physician to balance-bill the patient. Medicare regulators increasingly insinuate themselves into the practice of medicine by dictating the types of care that patients can or cannot receive. Physicians are verbally flayed for not regulating their peers; yet recently a group of physicians that tried to correct the malfeasance of a staff member was financially obliterated by the loss of an anti-trust suit that arose from their peer review actions. And of course, the malpractice liability crisis threatens the integrity of every practitioner.

The burden of physicians is exaggerated by their perception of impotence towards the harsh events swirling about them. Physicians who have been reared to and consumed by a career devoted to service and science are educationally and temperamentally ill-equipped to retaliate against the inhospitable forces menacing the profession. Anyone who listens to physicians discussing their plight is dampened by a steady drizzle of disillusionment. One hears complaints, fears and expressions of anguish. Physicians have retreated into a cocoon of passivity and defeatism. A request for solutions to their grievances is answered by a stentorian silence. Perhaps the first step in waging a successful rebuff of the pressures unfavorable to physicians and traditional American medicine is to change passivity to activity and aggression. Physicians possess an enormous but untapped reserve of power that could be recruited to advance the interests of modern medicine. Unfortunately, few physicians have an appreciation for the elements of power, for its sources and its implementation. Such an awareness is needed by all physicians if we are to regain control of medicine and our future.

The common conception of power evokes images of militarism, demagoguery and political intrigue, but a broader percept of power is more useful to our purposes. One definition, as proposed by the German sociologist Max Weber, states that power is the "possibility of imposing one's will upon the behavior of other persons." An analysis of power as a force that is to be used to submit others to one's own mindset is appropriate to medicine.

Power is a worthy subject for study. After all, power is the energizing force by which things get done. Its absence is accompanied by chaos and anarchy, conditions into which some feel medicine is declining. Its utility was recognized by prehistoric man who recorded its importance in his mythology. In Greek mythology Zeus personified power. Prior to his emergence, beings such as the Titans, Cyclopes and other assorted and unsightly creatures were thought to stalk about and continually stir up the

universe with lightning, fire, pestilence, disorder and other hostile and unpredictable, subhuman forces. Zeus conquered and controlled the unspeakable hordes who administered the chaos. He brought about order and predictability and therefore became the supreme god of the ancients. As physically dominant as Zeus was over the forces of disorder, he lacked an important attribute — the capacity to reason. Wisdom and reason belonged to his daughter, Pallas Athena, who ruled with Zeus. Neither could dominate the other; neither could successfully check the forces of chaos without the aid of the other. The mythological allegory is applicable today. Power unaccompanied by a system of ideas is destined to extinction, but ideas unattended by forceful proponents are condemned to barren oblivion.

Power unaccompanied by a system of ideas is destined to extinction, but ideas unattended by forceful proponents are condemned to barren oblivion.

Sources of power • What are the societal roots from which powers sprouts? Galbraith has distilled the number of sources to three: personality, property and organization.

Some students of power feel that the individual or his personality is the most important of these sources. History certainly supports this since the great weight of historical literature is devoted to recording the rise and fall of kings and emperors, warriors and generals, religious leaders and saints, artists and writers, poets and thinkers. In primitive societies, the individual acquired power by physical characteristics such as brute strength or martial ability. As civilization advanced, other qualities conferred power upon the individual such as the ability to persuade by intellectual rather than physical prowess. Intelligence, precision and clarity of thought, eloquent expression, humor and charm allowed some individuals to dominate others. Today scholarship, knowledge, creativity, originality and personal integrity are attributes that we expect in our leaders.

It is important to distinguish between leadership and authority. A leader acquires obedience by request; an authority can require obedience by fiat. Personal qualities impute power to the leader; legitimacy of the organization or the office within the organization confers power upon the authority. The exceptional leader possesses exceptional gifts of body and mind. Men such as Christ, Mohammed, Napoleon, Gandhi or Churchill possessed extraordinary persuasive gifts and derived their power from these traits. Conversely, authoritative figures, such as bureaucrats or officers of the armed forces or police, may be devoid of any personal leadership qualities but wield power by reason of their position.

In times of emergency or crisis, truly charismatic leaders may appear. Such persons are capable of collectively exciting masses of people to commit to a common cause. A charismatic leader dominates others by qualities inaccessible to others and by appealing to his followers with thoughts and actions untraditional or markedly disparate from those that govern everyday life. Medicine could benefit by the emergence of one or two such charismatic leaders.

A leader possesses two other qualities; a desire to lead and a realistic appreciation of the identity of his followers, i.e., his constituency. A crown of power has rarely been implanted upon the head of a person suffering a lack of fervor for it. Obversely, the zest for power has blinded many individuals to the limitations of the dimensions of their constituency. William T. Sherman expressed his disinterest in the United States presidency and it was not offered to him. Mussolini successfully united and organized the disparate bureaucracies of Italy but suffered defeat when he permitted his ambitions to roam beyond the boundaries of Italy.

Medicine desperately requires individual leaders on all levels of society. At first glance, this statement may seem unfair and untrue. After all, we have brilliant, dedicated leaders in science and academia and in some specialty organizations but these people do not represent medicine, in toto. Many physicians possess the educational, intellectual and persuasive capacities inherent in the finest of leaders. Unfortunately, they do not speak for the social, political and economic concerns that confront practitioners and patients in the United States today. We need national leaders endowed with vision, prominence, eloquence and national recognition. Unfortunately, our leaders have a flair for anonymity. An informal recent survey revealed that fewer than 40% of practicing physicians and less than 1% of patients knew the name of the current president of the American Medical Association. Medicine needs to breed a Lee Iacocca for its own purposes.

Medicine needs to better delineate its constituency. Its followers are not merely the doctors or the health system employees. The constituency encompasses the entirety of the patient population. An irresponsible resolution of the economic problems confronting medicine will adversely affect the entire nation. Since medicine's constituency is the entirety of the population, each individual practitioner needs to recognize his or her potential role as a leader.

The individual practitioner derives this power from the special nature of the doctor-patient relationship. The patient wants to trust and to believe the physician. This trust is a derivative of the physician's intelligence, and the special but arcane and difficult education and training. It is enhanced by the physi-

cian's experience, solemnity and mannerisms. Each physician has the power to influence the perceptions of the issues and the decisions of his patient population. Unfortunately, most physicians choose to allow their leadership to remain dormant. This latent power of the individual doctor needs to be activated.

Leadership in medicine must be fostered on county and state levels. Physicians who have the proclivity for and the skills necessary to effectively participate in the political and economic struggles in which medicine is embroiled must be identified and nurtured. Talented individuals with ambition for a national office must be encouraged by being given rapid access to higher position. Too frequently the ascent through the medical hierarchy from the local to significant national level demands a decade or two in the trenches. A short circuit through the system needs to be established to accomodate the ambitious, charismatic and knowledgable individual who can contribute to the economic, political and social well-being of medicine.

The exercise of power must be crisply distinguished from the illusion of power.

Since communication skills are essential to a leader and since physicians are perceived as such poor communicators, perhaps special courses need to be constructed for interested persons. Such training would be directed not just to the rudiments of public speaking but to the more difficult functions involved in interacting effectively with media personnel and politicians, and potentially hostile groups of listeners.

The exercise of power must be crisply distinguished from the illusion of power. An effective leader is judged by how well he can persuade others to adapt his solutions to their problems and his methods to their goals. Some speakers, such as some preachers and politicians, can emotionally electrify their audiences with verbiage but fail to affect behavior beyond the confines of the auditorium. Orators can excite a group by telling them what they want to hear but fail to mobilize the listeners to the action necessary to resolve their problems. Similarly, medical leaders who merely titillate the aural aesthetics of their audiences but who fail to alter the voting of politicians or consumers on issues vital to medicine are failures as power wielders.

The second source of power is wealth or property. Historically, a man's power and influence in society has been measured by the accumulated value of his possessions. In agrarian economies and up to the late 19th century in America, holdings of real property determined a man's influence. Land provided food and water, nourished domesticated animals and yielded wood and minerals necessary for shelter and energy. Primitive, feudal, and modern societies have constantly battled to extend their influence over greater tracts of territory. Land provided space for the work of peasants and taxation of the peasantry provided the financial means to support armies for defense and conquest. The greater the land area controlled, the larger the peasantry that could be supported and the greater the tax revenues derived. The system was self-perpetuating. The owner or lord was the most powerful man of the domain since he controlled the ultimate resource — the land.

The Renaissance was accompanied by a new source of wealth — trade. The merchant class evolved and proliferated. The merchant's wealth was not land-based but was rooted in hard money. The mercantile class gained influence by lending money to the powerful aristocracy to finance the latter's military and sundry other ventures.

The Industrial Revolution produced a new system of wealth — the machine and the factory which turned out large amounts of goods to be sold. Laws and government protected industry and industrialists. The influence of wealth became so great that Congress and presidents requested the opinions of such men as J.P. Morgan or John D. Rockefeller about issues quite remote from their realm of expertise. The words of the wealthy were sought, believed and acted upon.

In post-industrial America the influence of wealth has been dissipated. Affluence is no longer concentrated in the hands of the few but rather has been distributed to a large segment of society. Nevertheless, wealth continues to influence indirectly. Today influence is wielded by public relations, by the media and by political action committees. Since money purchases these implements of influence, it still retains some of its relationship to power.

An estimate of the power potential of physicians' wealth varies upon the observer. Doctors earned about 50 billion dollars last year — a sum approximately equivalent to the total international revenues of a single corporation — IBM. However, IBM earned its money with fewer than 390,000 employees. There are presently 500,000 physicians. Doctors' earnings represent a little over one percent of the gross national product, a rather insignificant amount. However, the decisions of doctors control approximately 70% of health care spending. Thus, they are responsible directly for the expenditure for about 280,000 billion dollars (7% of the gross national product), an amount that is significant. It is this economic power of doctors that is being assaulted by government. Unfortunately, doctors have not properly utilized their economic muscle to alter the thinking of health care legislators and power brokers.

A wag once stated that, "We live by the Golden Rule. He who holds the gold, rules." Unfortunately, doctors have unconditionally surrendered the fiscal concerns of medicine to government agencies and

insurance companies. None of these institutions benefit from a share in the traditions, humanity or scientific thought that form the infrastructure of American medicine. The culture of government and third party payors is foreign and distinct from that of physicians. Their appreciation of medical thinking has to be as limited as the physicians' understanding of political or underwriting processes. Most physicians who graduated from medical school in the post World War II era became impressed by the lack of interest for the fiscal side of medicine. Monetary concerns were denigrated by our professors and leaders. We have come to rue our economic naivete. We have unilaterally relinquished a mighty weapon in the battle for the domination of medicine. We must learn to master and to invent new uses for the economic tools still available to us.

Organization is the third source of power and is the element that bestows longevity and stability upon an entity. The church thrived after the death of the apostles because of the structure established in its early days. Armies, governments, and corporations survive and grow following the death or retirement of leaders, founders or chief executives because of the organization. Lenin's great success in imposing a communistic form of government in Russia during the anarchy of 1918 resulted from his rapid implantation of an organizational structure that he had designed years previously. Lenin died in 1924 yet his government form has survived for nearly seven decades because of the organization that he wrought and impressed upon Russia.

Organizations are composites of people who join together to arrive at one or more common goals. Organizations have advantages that individuals lack. They can recruit a multitude of personalities to accomplish their purposes, and they have access to a greater accumulation of wealth than do individuals. The soul of the organization is its managerial team. Management coordinates and orchestrates the organization's movement. It may permit individuals within to specialize in given fields that may contribute in a small way to the goals of the entire structure. Management is successful when it can integrate the activities of all its specialized, yet disparate parts into a harmonious effort that accomplishes the organization's stated aims.

The most powerful organizations are those that win strong internal acceptance of its goals and methods. Their members share a passionate belief in the purposes of the organization. Perhaps the strongest internal submission is observed in religious groups or in the military forces. But even modern corporations earn the internal faith of their members. Strong morale is essential to the success of any corporation. The more complete the internal submission of its members, the more successful will the organization be in winning submission of people external to it. In contrast, lukewarm internal acceptance of the organization's culture will yield unsatisfactory opportunity for external victories.

An organization must also focus its energies towards one or a few purposes. Those that have ill defined aims or who proceed apace towards a smorgasbord of goals will be far less successful than those that guide their resources into a narrower channel.

Politicians and the media speak of "organized medicine" but medicine is poorly organized. It has no single body that has captured the allegiance of all doctors. The American Medical Association has the structure, experience and longevity necessary to preserve medicine as the physician's province. The AMA is supposed to be the representative of all doctors but many physicians do not even belong to it. Most doctors do not know and do not even care what the AMA does. Doctors are members of many different medical organizations, each with its own purposes and some which interfere with or counteract the goals of others.

Traditionally, physicians have been a most difficult group of professionals to organize. Most are individual entrepreneuers unaccustomed and usually hostile to submission or commitment to any group other than their practices, patients and families. Medical societies are nothing more than loose confederations of such individuals who display a malignant apathy towards involvement or commitment to socio-economic or political purposes of a national association. By denying themselves the duty to join together and vigorously support a few national goals that are beneficial to all, physicians are giving away another powerful resource. Unless this sense of absolute independence and apathy towards organization is altered, government and industry will disassemble the current structure of the medical profession piece by independent piece.

Thus the sources of power are personality, wealth and organization. The medical profession has not capitalized on the sources available to it and thus finds itself perilously facing the loss of its tradition and independence.

Next month I will examine the mechanisms by which power is implemented. Hopefully by fractionating power into its component parts and examining each, we can better appreciate how the entire organism of power works and thereby better utilize it for our purposes.

Jacques R. Caldwell, M.D.
Daytona Beach

A Healthy Investment In YOUR Country's Future And YOURS

If you're willing to invest just 27 days a year in your country's future by serving in the Florida Army National Guard, we'll invest in your future by paying you a generous monthly annuity after you retire from the Guard. Payments are based on length of service and rank held at retirement. For more information on the Florida Army National Guard Medical Program please call...

Lieutenant Doug Hernandez

1-800-342-6528

Florida ARMY **National Guard**

GET MORE FOR YOUR ADVERTISING DOLLAR

Purchase A Display Ad in the

Journal of the Florida Medical Association, Inc.

Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203
(904) 356-1571

Physicians' Confidential Assistance

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874 — M D

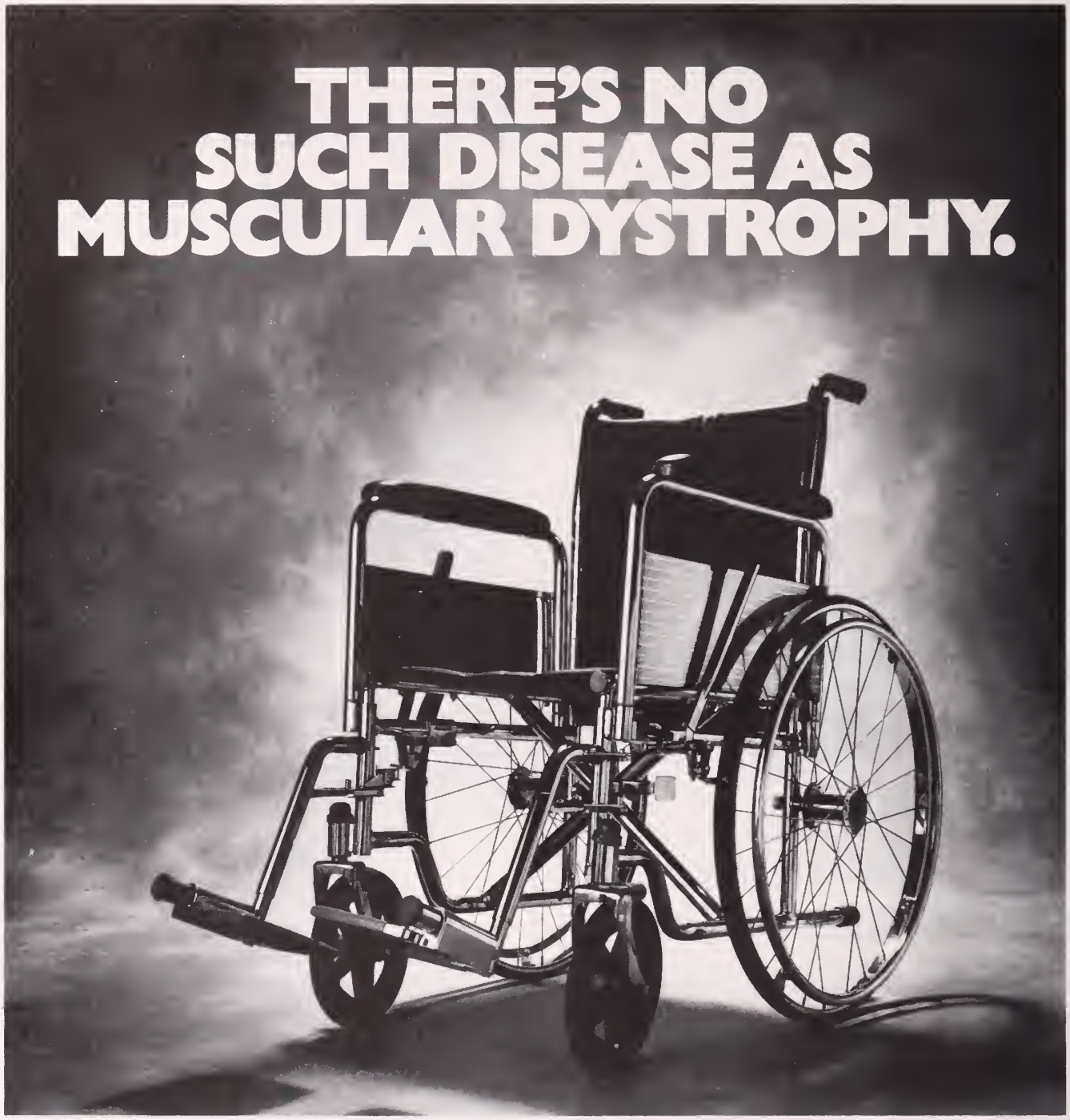
THE FLORIDA MEDICAL FOUNDATION 1956

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

THERE'S NO SUCH DISEASE AS MUSCULAR DYSTROPHY.



It's true. Because "muscular dystrophy" is the term for a *group* of twelve diseases—and no one disorder goes by that name.

Other facts about muscular dystrophy might surprise you, too. For one thing, the diseases aren't restricted to children. Anyone can be stricken, at any time.

For another thing, the Muscular Dystrophy Association battles not just the twelve muscular dystrophies, but twenty-eight other neuromuscular diseases, too.

At MDA, we're striving to put an end to all the devastating disorders you used to think of as muscular dystrophy.

And one day—we're determined—this chair will be empty for real.

MDA

Muscular Dystrophy Association, Jerry Lewis, National Chairman

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 221
- ☐ ENCORES!, 223
- ☐ SCAM OF THE MONTH, 227

☐ NOTES & NEWS

USF announces new endowed chair

University of South Florida President John Lott Brown announced today the establishment of a $1 million endowed chair in cardiovascular surgery in the University's College of Medicine and the complete endowment of the Ed C. Wright Chair in cardiovascular research.

The new chair will be funded by the Suncoast Chapter of the American Heart Association and will be known officially as the "American Heart Association, Suncoast Chapter, Inc. Chair of Cardiovascular Surgical Research." The Suncoast Chapter has also funded the Ed C. Wright chair, established in 1973, with totally private funds, and has now increased its contribution to qualify the chair under the Eminent Scholars Act.

President Brown said that this brings the total of endowed chairs at USF to eight in the medical center and 14 overall. Under the Eminent Scholars Act, the state provides $400,000 in matching funds when a university raises $600,000 from private sources, thus generating a $1 million endowment to attract outstanding researchers and scholars.

The Suncoast Chapter will also meet its commitment to fund for five years the Charles K. Donegan Career Development Award in Basic Cardiovascular Research. The award will then be funded in perpetuity by the University of South Florida. It provides the opportunity for doctors who have completed their residency to train for a career in research.

The announcement was made in conjunction with the American Heart Association's designation of February as "National Heart Month." Treatment of heart and circulatory disease, the country's main cause of death, will cost an estimated $76.8 billion this year, according to Heart Association figures. The mission of the American Heart Association is the prevention of premature death and disability due to cardiovascular disease and stroke.

"The establishment of these two chairs in cardiovascular research and surgery," said Dr. Charles L. Rast Jr., Executive Board Member of the Suncoast Chapter, "and the perpetuation of the Charles K. Donegan Career Development Award at USF reflect the deep continuing commitment of the Suncoast Chapter of the American Heart Association and of the people of the west coast area in the search of a solution to the major problem of illness affecting so many of our population. We are proud to be a part of this effort and to be able to provide such support to outstanding investigators in this field at USF."

Ray Olsson, M.D., Professor of Medicine and Biochemistry at the USF College of Medicine, currently occupies the Ed C. Wright Chair of Cardiovascular Research. Olsson will continue his present research program in the cause and treatment of heart disease, and has a national and international reputation for his excellence in cardiovascular research. He has been the chairholder since 1976.

"We established the first research chair at the University of South Florida," said Charles K. Donegan, M.D., of the Suncoast Chapter, "and we believe the money spent has accomplished so much that we thought it worthwhile to establish a chair in cardiovascular surgical research."

"Shortness of Breath" film discusses common concerns

Most people experience shortness of breath at one time or another — after exercising, for example. But if you are sill struggling to breathe or gasping for air after a few minutes' rest, that could be a sign that something more serious is wrong.

According to the American Lung Association, more than 68 million Americans suffer from chronic respiratory disease. "Shortness of Breath," the latest release in the HEALTHSCOPE public education series produced by the American College of Physicians, examines this common disorder and discusses its underlying causes.

Featuring New York City internist, Norma M.T. Braun, M.D., F.A.C.P., the 25-minute film follows Dr. Braun as she diagnoses and treats her own patients, including a young girl with asthma, a middle-aged woman who suffers from chronic bronchitis, and an older man who has complications due to tuberculosis.

Dr. Braun hopes this HEALTHSCOPE film will help people who suffer from shortness of breath "realize that something can be done for it, but it

cannot be accomplished with a magic pill. It requires the physician and patient working together to bring about a change in lifestyle. Since we cannot make the problem disappear, we must arrive at a state of functional living for the patient — one in which he or she does not just sit around and vegetate, '' she said.

A number of medical conditions can cause shortness of breath, affecting people of all ages. However, these conditions can be helped if medical treatment is begun early enough. What is most important is not to ignore other signs which might accompany shortness of breath. According to Dr. Braun, these include chest, arm or shoulder pain; coughing; spitting of blood; wheezing; rapid gain or loss of weight; fever; palpitations; faintness; choking; sweating; fatigue; pallor and feelings of panic. Whenever these signs occur, see a physician at once. Any unusual shortness of breath may be serious, but when combined with other symptoms, it could signal an even more serious condition, such as diabetes, heart attack or stroke.

''Shortness of Breath'' joins four other films in the ACP's HEALTHSCOPE public education series — ''Aches, Pains and Arthritis,'' ''Chest Pains,'' the award-winning ''Diabetes'' and ''Stomach Pains.'' The films may be obtained free on loan or purchased by calling the national office of the ACP at (800) 523-1546. The films are currently being shown to civic and social groups, business and industry, schools and on television. When placing an order, please allow four to five weeks lead time and specify a date two days in advance of the actual showing. All HEALTHSCOPE films are available in 16 mm film, ¾'', ½'' VHS, and ½'' Beta I and Beta 2 videotape formats.

HEALTHSCOPE is produced by the American College of Physicians under an educational grant from The Upjohn Company.

Joint commission announces new corporate report

The Joint Commission on Accreditation of Hospitals is pleased to announce the availability of its new corporate report. The updated report provides a brief description of the Joint Commission and its vital role in health care's growing voluntary accreditation movement.

Major accomplishments achieved by the Joint Commission in recent years are presented in the report. Also discussed are revisions to Joint Commission standards and enhancement of the survey process; expansion of accreditation activities; and initiation of new research, education, publications, and marketing activities to better meet the needs of the health care field.

The corporate report further serves to introduce the new Joint Commission logo. The stronger, more pronounced visual image establishes the Joint Commission as a forward-moving, influential force in the provision of quality health care in today's rapidly changing health care environment.

The new corporate report should prove to be informative and helpful about the Joint Commission. To receive a copy of the report, please write to the Marketing Department at the Joint Commission in Chicago, 875 North Michigan Avenue, Chicago, Illinois 60611, (312) 642-6061

Dr. Hanley appointed to *JFMA* Editorial Staff

Kay K. Hanley, M.D., a Clearwater pediatrician, has been appointed to the Editorial Staff of *The Journal* as an Assistant Editor by R. G. Lacsamana, M.D., Editor. Very active in organized medicine, Dr. Hanley also serves FMA as a member of the Board of Governors, as the Public Relations Officer, as the Editor of *FMA Today*, and as a member of several committees.

Historical issues needed

The Journal is looking for past historical issues. If you have any historical issues which you no longer need, please contact Sissy Crabtree, FMA Headquarters, (904) 356-1571.

Florida Medicaid Drug Utilization Review Program

In 1982 the Florida Medicaid Program entered into an agreement with the Florida Pharmacy Association to administer the Drug Utilization Review Program. It has been well documented that adverse drug effects can require hospitalization or prolongation of hospitalization. These remedial care requirements represent significant expenditures of funds and increased hardship on the recipient. In the United States about 3 billion dollars per year is spent as a consequence of adverse drug reactions. In Florida, factors such as easy access to pharmaceuticals, patient demands and larger percentages of elderly and refugee patients all suggest that the impact of drug induced disorders place an increased financial and logistic burden on the state's limited resources for health care. The drug program therefore, although a small component of the Title XIX program, can and does have a resounding impact on other more costly aspects of health care delivery.

The review process is conducted by regional committees consisting of physician and pharmacist participation, and is administered by the DUR staff in Tallahassee. The objective of the DUR program is to identify patients at risk for a possible drug induced or aggravated disorder and to communicate this information to the medical providers as identified from the drug history profiles generated. These profiles are based on the billings submitted to HRS for payment. This program is informational in nature only and requests that the provider incorporate this additional information into their consideration of the patient's drug therapy review. Pharmacists, being part of the health-care team, are asked to consult with the prescribing physician(s) and assist in evaluating the patient's drug therapy regimen. In all cases it is the physician who has final responsibility for the patient's care.

DUR is a process of inquiry and discovery which triggers a message to community and hospital practitioners (pharmacists and physicians) and establishes a communication loop which is completed by feedback from the health care provider. The end product of all the interactions and energies expended is "education through discovery." By providing more complete patient/medical information, the program can assist the practitioners in their therapy decisions. The traditional approaches to DUR have employed quantitative criteria (eg. number of prescriptions, dollars spent/patient, etc.). The Florida program utilizes both quantitative and qualitative criteria. The DUR program in Florida utilizes therapeutically oriented criteria, which were first developed in 1978. The goal of the DUR program encompasses a decrease in the incidence of drug treatment failure and drug induced illnesses, thereby decreasing the need for costly remedial care services. To accomplish this goal several objectives were adopted:

1) Reduce Underutilization
2) Reduce Overutilization
3) Reduce the risk of Iatrogenic Effects and Adverse Reactions
4) Reduce Contraindicated Drug Combination Uses
5) Reduce the risk of Drug Therapy Contraindicated By Diagnosis

A battery of therapeutically oriented drug and disease criteria are used to generate the profiles reviewed by the committees. Over 550,000 patient medical histories are scanned and compared against pre-selected therapeutic criteria to identify those recipients whose drug patterns exhibit potential problems. The therapeutic criteria utilized are established by a Therapeutic Review committee consisting of physicians and pharmacists representing the Colleges of Medicine and Pharmacy, Florida Medical and Pharmacy Associations and the Department of HRS, as well as input from regional committee members.

The cornerstone to the success of the DUR program has been the participation of local health care professionals interested in improving the quality of health care in their region. There are five (5) regional committees consisting of physician and pharmacist participation that review the patient medication profiles.

ENCORES!

The national lottery

An epidemic of costly litigation is sweeping the country, and the time to halt it is now.

Witness the efforts of lawyers after any disaster, such as an airplane crash or the tragedy at Bhopal, India. They rush to the scene and descend upon the distraught survivors and relatives. They rent movie houses and auditoriums to make their pitch for clients. In law offices all over the country, lawyers are hard at work finding and convincing people to file suit. It used to be that lawyers tried to persuade their clients to settle disputes. No longer.

The pot of gold for lawyers is a huge fee or a participation of up to 50 percent in court awards. Staggering court awards in cases whose results seem to violate common sense have made it worthwhile for the lawyers. Recently, a man attempted suicide by jumping in front of a New York subway train. He sued the Transit Authority because the train stopped in time to save his life but not quite soon enough to avoid some physical damage to him. He collected more than $600,000.

And what about the tenant, celebrating his birthday on a Sunday afternoon, who drowned when he drunkenly tried to walk along the bottom of his apartment-house swimming pool in the full view of his wife and 15 close friends? His wife successfully sued the landlord's insurance company.

The result? Soaring premiums for liability insurance to cover this increased and indeterminate financial exposure. Legal costs and insurance have become an increasing component of the price of goods and services. Even the availability of some consumer services is being curtailed.

Personal-injury awards, especially jury awards, are out of touch with reality. They are often based on estimates of how much money the defendants have rather than whether they are at fault. The awards have become a means to redistribute wealth rather than a measure of fault or a deterence to undesirable conduct. It may appear to a jury that an insurance company, individual, corporation, or government with "deep pockets" is paying the claim. The truth is that millions of "little pockets" are

actually paying the cost either through higher prices for products and services or through higher insurance bills.

It is time to re-examine the manner in which the nation's judicial system deals with injured parties.

First, a method must be developed to tilt the judicial system against increased litigation. One approach would be to compensate a successful defendant for the cost of the defense against an unsuccessful plaintiff. The obvious benefits would be a more serious and thoughtful analysis of a claim prior to bringing a lawsuit and a reduction in the number of frivolous claims. It would also bring pressure to bear on achieving a reasonable settlement of the matter prior to running up large legal fees.

Second, the states should follow the example of California in limiting contingent fees to lawyers. These fees theoretically balance economic power for those who cannot afford the cost of bringing a case on an hourly basis. In practice, however, contingent fees have fostered an atmosphere of a no-cost lottery for clients. The California bill caps the contingency fees at 40 percent of the first $50,000 of the settlement, ranging downward to 10 percent of any award above $200,000.

Third, damages awarded for "pain and suffering" and other noneconomic losses should be capped. California has set a limit of $250,000, controlling the awards in medical-malpractice suits for such vague matters as grief, mental distress, etc.

One of the great principles of American jurisprudence has been access to justice through the court system. But the right to swing your arm stops at the point of another man's chin. The right to access to the courts must not be permitted to bury our society under a mountain of legal pleadings that raise insurance bills for all. To permit this abuse is to turn the courts into a national lottery in which the winning names are the lawyers and certain plaintiffs who are picked by judges and juries, while each of us, every day, is the loser.

Mortimer B. Zuckerman
Chairman and Editor-in-Chief
U.S. News and World Report

Reprinted with permission from *U.S. News and World Report*, Jan, 27, 1986, page 80.

Dial-a-lawyer

Doctor: Hello? Is this 1-800-LAWYERS?

Lawyer: Yes, it is. Please give me your Visa number and expiration date of your Federal BNDD number if you are a physician, osteopath, or veterinarian.

Thank you. How may we help you paddle up life's legal rivers?

Doctor: First of all, I think this 24-hour-a-day legal question anwering service is a great idea. We doctors are always being second-guessed, but now we can have that legal advice right from the beginning.

You see, I'm the doctor on call tonight in the emergency room, and I've got this drunk here who was punched in the nose. He won't let me examine him.

Lawyer: Was he the fighter or the fightee?

Doctor: He's not sure.

Lawyer: What?

Doctor: He drank a fifth of Old Grand Dad before arriving.

Lawyer: Did he sign a permission-to-treat form?

Doctor: Yes, he did.

Lawyer: Then I see no problem. You'll just have to treat him.

Doctor: He did sign the chart permission form, but I doubt that Screw You is his legal name.

Lawyer: So do I. This could be a problem. Why don't you ask him if he wants to be treated? A verbal permission is better than nothing.

Doctor: I did, but he wanted to talk about my mother's nationality and sexual preferences instead.

Lawyer: Your patient has come to your emergency room, and you have an obligation to treat him.

Doctor: Easy enough for you to say, but this fellow wants to tear my head off. By the way, let's say this guy punches me, too. Can I sue him?

Lawyer: Well, we lawyers are an argumentative lot, and that question could go either way, especially if a 40 percent contingency fee were at stake. I think the real question here involves that venerable legal tenet called The Law of the Deep Pockets. Are you familiar with it?

Doctor: No, but I'm afraid to ask.

Lawyer: To put it in a nutshell — at our dollar-a-minute telephone charge, I'm sure that's what you want — if you have insurance, you can and you will be sued.

Doctor: Even if not guilty?

Lawyer: Yes.

Doctor: How about the patient?

Lawyer: Does he have insurance?

Doctor: Not unless it's on the Harley-Davidson sitting out in the parking lot.

Lawyer: That brings us to the other cornerstone of modern legal thought, which is, by the way, the converse of The Law of The Deep Pockets. Plainly stated: A Bum is Judgment Proof.

Doctor: So if I don't treat him, I get sued, but if he beats me up, that's too bad.

Lawyer: So to speak.

Doctor: Wait a minute. I think my problems are over. The patient just took a swing at the investigating police officer. His nightstick accidentally struck the patient on the head, and he's out cold. I'll

call the neurosurgeon in. Besides, the city must have an excellent liability policy.

Lawyer: Isn't that called "turfing" in medical parlance?

Doctor: Yes, it is. But I'm asking the questions here. While you're on the live, how about a quickie?

Lawyer: Lawyers don't do quickies, not at $75 an hour.

Doctor: I have another patient here, a cute little four-year-old named Sally. She fell of her Hot Wheels and bumped her forehead. She didn't lose consciousness and looks entirely normal to me right now.

Lawyer: What's the problem?

Doctor: Her mother watched "Half-Hour Magazine" last week. Some guy said that the only way to really diagnose head injury is with a CT scan. If I order the test, the girl would receive an unneeded dose of radiation, and it would be expensive.

Lawyer: What are the chances that there could be something wrong on the scan?

Doctor: Oh, I'd guess about one in 500.

Lawyer: Are you a betting man?

Doctor: Not usually.

Lawyer: Do you want to see your whole medical career go down the drain in case you're wrong?

Doctor: No, but. . .

Lawyer: Tell you what, go back and explain to the mother what you've just told me. I'll do some quick research on the issue and put you on hold. Besides, there is a wife-beater on the other line who's frantic and needs my advice.

Doctor: Hello? I talked with the mother and she said no go. She wants the CT scan and mumbled something about paying all those insurance premiums, but when you need the coverage, they always try pinching pennies.

Lawyer: Let's see. *Roe vs. Wade. . .Miranda. . .Escobedo.* Ah, here it is. An interesting case on the West Coast. Just last year a teenager fell down and hit her head. She also didn't lose consciousness. The physician who first saw her didn't find any physical signs of closed head injury and refused any further tests. The girl complained of headaches for the next week and finally she managed to convince another doctor to perform a CT scan on her.

Doctor: What did they find?

Lawyer: Nothing. Unfortunately, they sued the first doctor anyway and collected ipso facto because he caused her the pain and suffering of not knowing that there was anything wrong. What did your four-year-old's mother say?

Doctor: First of all, she took out a note pad and copied my name off my name tag. Then she asked me if that was my legal name. Right now she's calling her lawyer.

Lawyer: Did you inform her of our service?

Doctor: No.

Lawyer: Just kidding. I rest my case. Look on the bright side. This country already spends $30 billion a year on preventive medicine. So what's another $600? Fire up the CT scanner.

Doctor: I will. First I need to get permission. I'll have to call 1-800-BUREAUCRAT, the clearinghouse for hospital admissions and tests not covered under 1-800-FEDERAL, the clearinghouse for Medicare and Medicaid patients.

Lawyer: Just mention our discussion. If they refuse, inform the mother that she can sue them, too.

Doctor: Well, it's been interesting.

Lawyer: And your bill is only $24.95. Now isn't that a small price to pay to sleep well at night?

Doctor: It certainly is.

Lawyer: Don't forget to tell your colleagues about our new program — Rent-A-Lawyer. For the next month, you can take advantage of our introductory offer. We'll give you an attorney who will follow you on rounds and advise you on any legal pitfalls right on the spot. He even brings his own lab coat. At just $495 a day, this is really a bargain.

Have a nice day.

Dale Orton, M.D.

Reprinted with permission from *M.D. Magazine*, January 1986.

Legible, literate, lucid

I suspect record keeping has always been an important aspect of medical care. In fact, from a historical perspective, the classical knowledge breakthroughs have been based on someone's superb observation and recording skills. I also suspect that the average doctor has always rebelled at the chore since more of us practice the art than practice the science, and probably more patients need the art than need the science. Put another way, if medicine is a balance of art and science, most of us weigh the practice heavily on the side of the art, and the care that most people need should be so weighed.

I think that those doctors who are very scientifically oriented cultivate recording skills early in their training, or perhaps they are born with them as a constitutional trait. On the other hand, those less scientific care not for record keeping and look on it as an unnecessary nuisance imposed by an outside authority. First the authority was the schoolteacher, next the chief, then the accrediting agency, now the government, the roles becoming progressively more onerous.

Attempts to recall formal instruction in record keeping during my educational process were fruitless. To the best of my recollection there was none, other than the formal outline to be found in texts dealing with physical diagnosis. What little individual help

I received came from upper classmates or a further advanced resident and when it came to accurately describing events or conditions, in most cases that was an example of the blind leading the blind. As a result, form become all important, content was incidental, and medical records worthless. If all elements of the history and physical examination were present, the record was acceptable, even though it contained no information as to what, when, or how. Conversely, a beautifully descriptive record was inadequate if no mention was made of the family history or what childhood diseases had been experienced. It is not uncommon now to review a number of records from the same doctor and find each one almost a duplicate of the others, stock phrases being used over and over to "fill in the blanks." Similarly, with operation and other procedural reports, the mind is turned off, the speech or pen is turned on and a canned report is recorded. The alternative, seen too often, is garbled verbiage which is completely unintelligible.

Too often is heard, "Well, what difference does it make? I took good care of the patient and I knew what I did and why I did it." In this day and time it makes a big difference and for a number of reasons. While each patient has a single, mostly responsible physician, almost all are also seen by others, either covering or consulting for the attending. Good care demands that they have the benefit of a good description and the reasoning and logic behind what is being done. In case of future litigation also, accurate and complete descriptions are of utmost importance. Finally, since our reimbursement system is based on diagnosis and procedure, whether or not we get paid and how much, depends upon documentation.

I do not know where the fault lies, early education, medical school, or postgraduate training but the general quality of most doctors' records ranges from poor to awful. If the educational system needs to reemphasize the three Rs, then the medical system needs to emphasize the three Ls, LEGIBILITY, LITERACY and LUCIDITY.

James Conn, M.D.
Tallahassee

Reprinted with permission from *Cap Scan, The Newsletter of the Capital Medical Society*, November 1985, No. 138, pg. 1.

Utilization review can curb costs while retaining freedom of choice

Given the opportunity, most physicians will opt for the status quo. The choice doctors now face, however, is no longer whether they will accept utilization review or other cost-containment mechanisms. What physicians must now decide is how to keep costs down while maintaining the status quo — traditional fee-for-service medical practice.

Most critics refer to utilization review as "looking over the doctor's shoulder." However, utilization review can be highly effective in reducing medically unnecessary admissions with no decrease in quality of care. In addition, it can be a powerful weapon in physicians' battles to remain independent from the onslaught of alternative delivery systems.

Third-party payers have argued for some time now that providers — physicians and hospitals — have abused the present payment system to improve their financial status. Payers' commitment to controlling the hemorrhage of dollars has led to such cost-containment efforts as shifting costs through co-payments and deductibles; development of HMO's and PPO's, and utilization review.

Bolstering Relationship • Of these, only utilization review can help bolster the traditional fee-for-service patient-doctor mode of practice. However, this is only possible when reviewers have no conflicts of interest. In-house hospital review committees — medical organizations with a provider constituency — or those run by third-party payers have interests to serve other than those of the patients. Independent utilization review, performed by an objective professional medical organization assisted by accountable physicians, is perhaps the easiest, least restrictive method of cost containment.

Early efforts of utilization review by the Blue Cross plans and large independent insurers did little to contain costs. Insurance carrier-sponsored, in-house review programs are not subject to the same accountability standards demanded of the physicians whose practice patterns they monitor and sanction.

In many instances, this utilization review process involved only a WATS line, a nurse and a set of PAS length-of-stay books. Following this pattern, other small carriers, third-party administrators, brokers and consultants soon got into the utilization review act. Their efforts were as ineffective in their review activities as those of the insurance industry giants.

What was created on both ends of this spectrum was a mechanism for intruding into the practice of medicine in the name of cost containment. In most cases, physicians were given a toll-free number to call when hospital admission for a patient was desired. A nurse answered the phone, asked the required demographic and medical information and then assigned a length of stay based on PAS data.

If the patient needed more hospital time, the physician had to make more phone calls. At least 95% of those requests were approved by the nurse. The rest of the time, an in-house physician may have been asked his opinion. Rarely, if ever, did the insurance

company physician talk to the attending physician about the clinical condition of the patient.

Meanwhile, the collection of WATS numbers the attending physician had to call continued to increase. In June 1985, for example, physicians in a large Southern hospital had no fewer than 18 insurance carriers, and several other small companies to call in order to receive preadmission and continued-stay certification.

With all of this administrative intrusion, an authentic review mechanism still was not in place. Utilization review remained a perfunctory process with some cost benefits stemming from the so-called sentinel effect — meaning that physicians will use fewer services when they know they are being watched. Nonetheless, insurance companies promoted the mistaken belief that they had put a genuine cost-containment program in operation.

Physicians were also deluded into thinking that the decentralized utilization review process is a simple procedure requiring only a few seconds of their time. While they accepted this token process, they also rushed to enroll in every HMO around, simultaneously bemoaning the changes taking place in health care.

At the same time, many varieties of PPOs were being developed by payers, physicians, hospitals, consultants and others. All had some mechanism built in for utilization review. One often gets the impression, nonetheless, that most of these PPOs were being created in a futile effort to retain the status quo.

Despite this proliferation of alternative delivery systems, the heart of cost containment is still utilization review. And, at the very core of the process is a commitment to preserve and buttress the traditional patient-doctor, freedom-of-choice relationship.

Utilization review permits maximum freedom of choice for the patient in the selection of a physician or health care facility. When the review organization is independent, unfettered and dedicated to eliminating unnecessary, and medically unsound, procedures and hospitalizations, while helping to maintain quality health care, the independent physician has discovered a new ally, not an adversary.

Utilization review is most effective when it is performed independently — doctor to doctor, free of financial involvements, referral patterns, constituency considerations, or other personal relationships between the reviewing and attending physician. The reviewing physician must believe in accountability, and have a proven record of effective utilization and little, or no, relationship with the attending physician.

In independent peer review, the trade-off is simply that attending physicians must develop an openness to change and give enough of their time to permit this kind of rational utilization review process to take place. Such a process will produce a positive environment in which health care costs can be effectively managed without compromising the quality of care. The result will be care that is as cost-effective as that provided by any alternative delivery system, while retaining freedom of choice for both the patient and the physician.

Robert J. Becker, M.D.
Joliet, Illinois

Reprinted with permission from *Physicians Financial News*, January 30, 1986.

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"The Phantom Refill Scam"

Investigations of controlled drug prescriptions (Schedule III, IV and V files at pharmacies) are revealing an ever increasing number of prescriptions with refill numbers which have been altered (increased) by the patient — unknown to the physician/dentist.

Professional patients, especially those addicted to, or selling the CODEINE containing Schedule III Controlled Drugs, Schedule IV TRANQUILIZERS and sleep medications, are commonly adding refills to prescriptions which are not properly completed by the physician/dentist.

Caution • Physicians/dentists are reminded to mark refill information so that alteration cannot easily be made or to place an ϕ in the refill column.

Pharmacists are cautioned to be alert to forged or altered refill information. Verifying refills with the physician/dentist involved is the best safeguard. Also, it is advisable to check the quantity and strength with the prescription directions. Be concerned if the patient is returning too soon or seems not to be taking the medication properly. A professional pharmacist should ask these questions.

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

29 Glen Cove Ave., Glen Cove, N.Y. 11542 516-676-4300

Our members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
American Health(10)	14.95	12.95	11.95	
American Heritage(6)	24.00	18.00	18.00	
Amer.Photographer(12)	19.90	9.95	6.65	8
Americana(6)	11.95	11.95	9.95	
ArtNews(12)	29.95	25.95	25.95	
Artist's Mag(12)	21.00	21.00	9.97	9
Atlantic Monthly(12)	9.95	9.95	9.95	
Audio(12)	17.94	8.97	8.97	
Baseball Digest(12)	14.95	14.95	7.97	10
Basketball Digest(8)	9.95	9.95	7.97	
#Better Hms-Gdns(12)	12.97	6.49	12.97	
#Bicycling(10)	15.97	8.00	12.97	
Black Enterprise(12)	15.00	9.00	7.50	
Bon Appetit(12)	15.00	15.00	15.00	
Boys Life(12)	13.20	13.20	11.97	
Car & Driver(12)	17.00	11.99	11.99	
Cats (12)	17.50	17.50	12.50	
Cat Fancy(12)	17.97	17.97	12.97	
Changing Times(12)	15.00	9.97	9.97	
Child Life:age 6-10(8)	11.95	11.95	9.97	
Childrens Dig:7-11(8)	11.95	11.95	9.97	
Commentary(12)	33.00	33.00	33.00	
#Connoisseur(12)	19.95	10.00	19.95	
Consumers Digest	14.97	14.97	10.97	
Consumers Reports(12)	16.00	16.00	16.00	
#COSMOPOLITAN(12)	**24.97**	**15.00**	**24.97**	
Cruising World(12)	18.00	18.00	14.00	
#Discover(12)	24.00	13.00	14.95	
Dog Fancy(12)	17.97	17.97	12.97	
Downbeat(12)	15.75	15.75	7.95	
Ebony(12)	15.00	14.00	9.97	
The Economist(52)	85.00	51.00	51.00	
Ellery Queen Myst(13)	22.75	19.50	9.97	10
Esquire(12)	17.94	9.95	9.95	
Essence(12)	12.00	9.96	9.00	
Family Circle(17)	14.97	14.97		
Family Computing(12)	19.97	11.97	11.97	
Family Handyman(10)	9.95	9.95	5.95	
Field & Stream(12)	13.94	7.94	7.94	
Fifty Plus(12)	15.00	11.97	11.97	
Financial World(26)	41.95	24.94	18.95	18
Food and Wine(12)	18.00	9.00	15.00	
Football Digest(12)	12.95	12.95	7.97	10
Forbes(28)	42.00	42.00	28.00	
Fortune(26)	42.00	21.00	21.00	
Games Magazine(12)	15.97	15.97	15.97	
Gentlemens Quart.(12)	18.00	13.50		
Glamour(12)	15.00	12.00		
Golf Digest(12)	19.94	11.97	11.97	
Golf Magazine(12)	15.94	8.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Good Housekeeping(12)	14.97	9.97	14.97	
Gourmet(12)	18.00	13.50	15.00	
#Harpers Bazaar(12)	16.97	8.97	16.97	
Harpers Magazine(12)	**18.00**	**9.97**	**9.97**	
Health(12)	22.00	13.32	11.00	
High Fidelity(12)	13.95	6.98	6.98	
Home(12)	15.00	15.00	15.00	
Home Mechanics (12)	11.94	8.97	8.97	
The Homeowner(10)	18.00	13.97	9.00	
Hot Rod(12)	13.94	8.97	8.97	
House and Garden(12)	24.00	18.00		
#House Beautiful(12)	15.97	7.99	15.97	
Humpty Dumpty:4-7(8)	11.95	9.97	9.97	
Jerusalem Post(24)	18.46	18.46	15.97	
Jet(52)	36.00	30.00	26.00	
Ladies Home Jrnl(12)	20.00	15.00	10.00	
#Life(12)	32.50	16.25	25.00	10
M:Civilized Man(12)	24.00	19.95	17.95	10
Mademoiselle(12)	15.00	12.00		
#McCalls(12)	11.95	11.95	11.95	
Metropolitan Home(12)	15.00	7.50	7.50	
Modern Photography(12)	13.98	7.98	6.99	
#Muney(12)	29.95	15.00	19.95	
Mother Jones(12)	18.00	12.00	12.00	
Motor Trend(12)	13.94	7.97	7.97	
MS Magazine(12)	16.00	10.97	10.97	
The Nation (52)	28.00	28.00	9.95	24
Nation's Business(12)	22.00	12.97	12.97	
Natural History(12)	20.00	15.95	15.95	
N.E.Journal of Medicine(52)	60.00			
New Republic (52)	48.00	48.00	28.00	
#New Shelter(9)	10.97	5.50	9.97	
N.Y. Rev.of Books(17)	28.00	28.00	25.95	
New Yorker(52)	32.00	32.00	20.00	
#Newsweek(52)	41.00	21.80	21.80	
Omni(12)	24.00	15.96	15.96	
1001 Home Ideas(12)	22.00	15.97	11.00	
Organic Gardening(12)	12.97	9.97	9.97	
Outdoor Life(12)	13.94	7.97	7.97	
Outside(10)	16.00	12.00	8.97	
Ovation(12)	16.00	8.00	8.00	
PARENTS(12)	**18.00**	**9.00**	**11.95**	
Penthouse(12)	36.00	30.00	30.00	
People(52)	56.50	56.50	28.25	
Personal Computing(12)	18.00	18.00	8.97	9
Petersens Photog(12)	13.94	6.97	6.97	
Playboy(12)	25.00	21.50	21.50	
#Popular Mechanics(12)	13.97	7.00	13.97	
Popular Photogr.(12)	11.97	5.99	5.99	
Popular Science(12)	13.94	7.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Prevention(12)	13.97	7.00	13.97	
Psychology Today(12)	15.99	8.00	12.97	
Reader's Digest(12)	15.41	15.41	15.41	
#Redbook(12)	11.97	6.97	11.97	
Road and Track(12)	17.94	11.99	12.99	
Rolling Stone(26)	19.95	19.95	17.95	
The Runner(12)	16.97	12.97	8.97	
#Runner's World(12)	19.95	10.00	12.97	
Sail(12)	21.75	21.75	21.75	
Saturday Eve.Post(9)	12.97	12.97	12.97	
Savvy(12)	12.00	12.00	6.00	
Science '86(11)	18.00	18.00	13.95	
#Science Digest(12)	13.97	6.99	13.97	
Scientific Amer.(12)	24.00	24.00	24.00	
Self(12)	15.00	12.00	N.A.	
Seventeen(12)	13.95	13.95	13.95	
Shape(12)	20.00	20.00	8.97	6
Ski(8)	11.94	6.97	6.97	
Skiing(7)	9.98	4.99	4.99	7
Skin Diver(12)	13.94	7.97	7.97	
Sport(12)	12.00	7.97	7.97	
Sporting News(24:6 mo)	22.50	11.97	11.97	
#Sports Afield(12)	13.97	6.99	13.97	
#Sports Illustr.(54)	56.50	34.00	29.45	
Stereo Review(12)	9.97	4.99	4.99	
Teen(12)	12.95	7.95	7.95	
Tennis(12)	17.94	8.97	8.97	
#Time(52)	58.25	29.25	28.00	50
#Town & Country(12)	24.00	12.00	24.00	
Travel & Leisure(12)	25.00	12.50	25.00	
TV Guide(52)	31.20	31.20	26.00	
#U.S.News/Wrld.Rep(52)	41.00	20.50	20.50	
Vegetarian Times(12)	19.95	14.95	14.95	
Video(13)	15.00	15.00	7.50	
Video Review(12)	12.00	6.97	6.97	
Village Voice(52)	32.76	32.76	22.00	
Vogue(12)	24.00	21.00		
W Magazine(26)	26.00	23.00	17.95	
Weight Watchers(12)	13.97	11.97	11.97	
Woman's Day(17)	15.13	15.13	15.13	
Women's Sports(12)	12.95	12.95	8.95	
Workbench(6)	6.00	6.00	5.00	
Working Mother(12)	11.95	9.95	9.95	
Working Woman(12)	18.00	12.00	15.00	
World Press Review(12)	16.95	16.95	14.98	
Writer's Dig.(9 iss)	18.00	9.97	9.97	
Yankee (Colonial)(12)	15.00	15.00	12.97	
YM(12)	14.00	10.95	10.95	

#BUSINESS CARD NEEDED FOR OFFICE PRICE				

HUNDREDS OF OTHER TITLES AVAILABLE! PLEASE SEND US YOUR REQUESTS!

FMA MAGAZINE PROGRAM
29 Glen Cove Ave., Glen Cove, N.Y. 11542

MAIL MAGAZINES TO:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AFFILIATED HOSPITAL/SCHOOL _____
Required for Educator rates

VISA or M/C No. _____ Exp. Date _____

Prices subject to publishers' changes

PLEASE SEND THE FOLLOWING MAGAZINES:

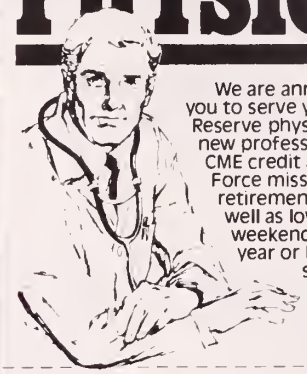
NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

All subscriptions are for one year unless otherwise noted
Guarantee: Our prices are the lowest, our service the best
New Orders: Publishers take from 6 to 12 weeks to start your subscription
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date

Please make checks payable to FMA Magazine Program

FLMD186

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HQ 10 AF/RSH
Bergstrom AFB, TX 78743-6002

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Prior Service? Yes ____ No ____

Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE

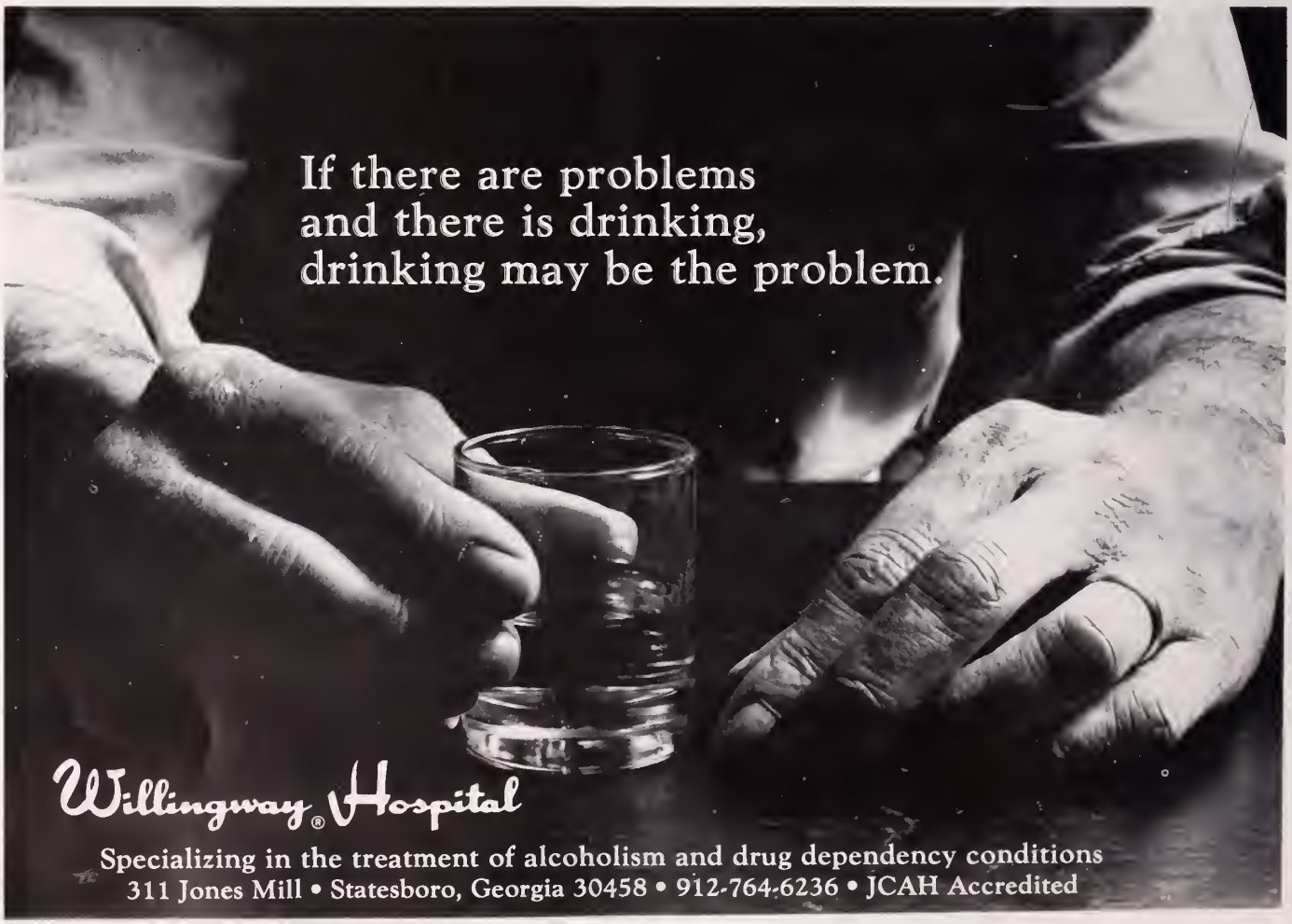
Government Printing Office Bookstore

Jacksonville, Florida

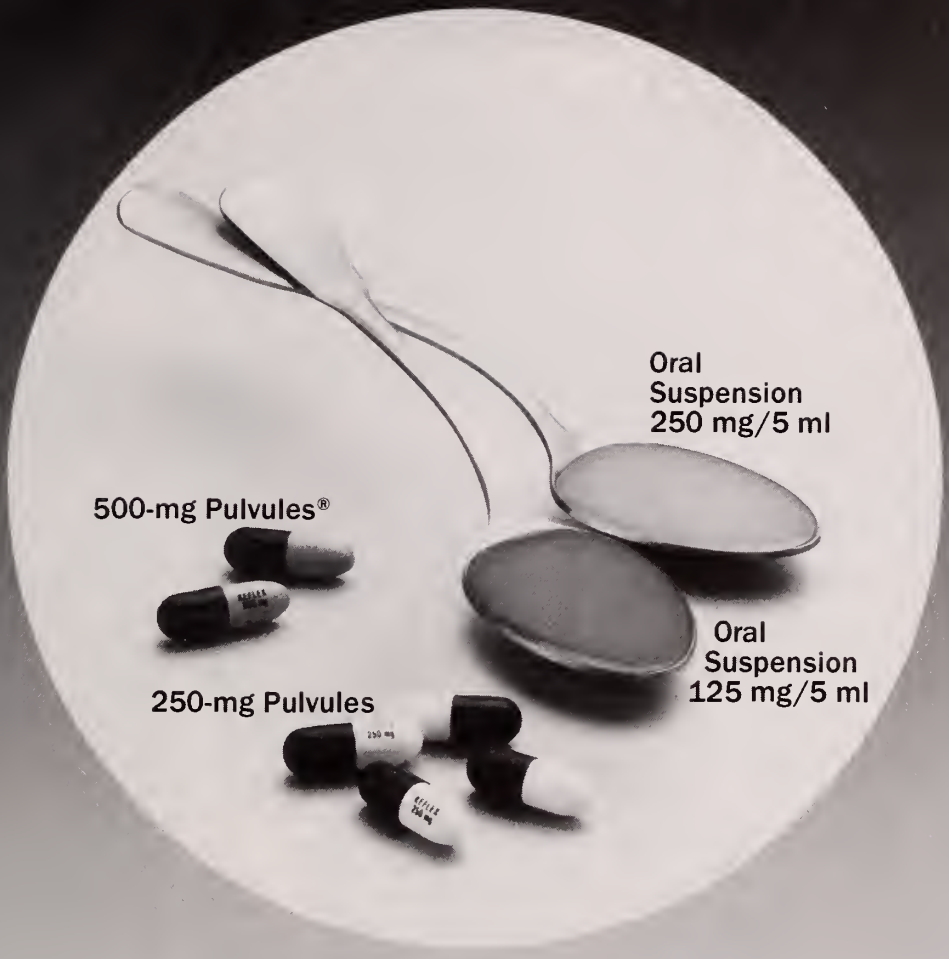
The Government Printing Office Bookstore in Jacksonville, Florida carries in stock the International Classification of Diseases, 9th edition (ICD-9). This three-volume set contains the codes used in filing insurance claims. Price: $29.00 (paper edition) and $40.00 (cloth edition).

The book store also carries in stock four different formats of the HCFA Form 1500, used for filling out Medicare claims. The two-part carbonized snap-out form used most by doctors sells for $13.00 per 100-count package. Pre-payment is required, although there is no tax or no postage charge for 4th class mailings. Make check payable to Superintendent of Documents, or charge orders to MasterCard, Visa or Choice.

Government Printing Office Bookstore
Federal Building, Room 158
400 West Bay Street
Jacksonville, Florida
(904) 791-3801



Easy To Take



Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA

420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2406

EMPLOYEES APPRECIATE THE PAYROLL SAVINGS PLAN.

JUST ASK THE PEOPLE AT THE BOEING COMPANY.

"My folks gave me a Bond for my birthday every year. Now I can do the same for my kids."
—Vaughn Hale



"It's certainly a painless way to save. The money comes directly out of my paycheck every two weeks."
—Florence Perry

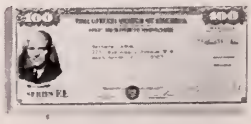


"This is one way I can support my government and save at the same time."
—Douglas Scribner



U.S. Savings Bonds now offer higher variable interest rates *and* a guaranteed return. Your employees will appreciate that. They'll also appreciate your giving them the easiest, surest way to save.

For more information, write to: Steven R. Mead, Executive Director, U.S. Savings Bonds Division, Department of the Treasury, Washington, DC 20226.



U.S. SAVINGS BONDS
Paying Better Than Ever

A public service of this publication.

BALANCED CALCIUM CHANNEL BLOCKADE!



Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

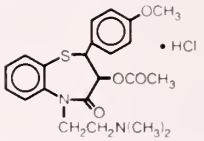
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LOH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity
Other:	Polyuria, nocturia

The following additional experiences have been noted.

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LOH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered.

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LO_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LO_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES INC
KANSAS CITY, MISSOURI 64137

Frozen star

By George Greenstein. Price $14.50. Hardback by MacDonald Books in United Kingdom, paperback by Freundlich Books in United States.

Where to begin writing about this remarkable book is difficult for it is all a beginning — at least it was for me, and that alone is one of the greatest things about this book. It makes reading about a profound subject both easy and intriguing for the beginner. No wonder then that is has not only won the Phi Beta Kappa award for the best book in science this year but also the coveted prize for excellence from the American Institute of Physics.

The book begins with an explanation of what happens when stars fall into black holes. A black hole is described as a pathology of gravitation — a jail (gaol) as in the "black hole of Calcutta." In it all matter is entombed forever. This beast is probably responsible for the violent cataclysms that are occurring in our "peaceful heavens" at all times.

To help us understand something of what is going on in space, Greenstein explains Einstein's theories and how they changed our ideas of gravitation. Newton considered it a force. Einstein's equations treat it as a distortion of the very nature of time and space. His remarkabaly intuitive brain theorized this without books, telescopes, or government grants; but it was Karl Schwarzschild who finally solved Einstein's equation to give us black holes.

We are told that anything can become a black hole, and the way this is explained to us is fascinating. It can happen where anything is compressed to its Schwarzschild surface. The critical radius of the sun, for instance, is 1.75 miles, and it is at the radius that escape velocity from its surface equals the velocity of light (186,000 miles per second).

Modern researchers have gone beyond Einstein and Schwarzschild, and with the new geometries they talk of rotating black holes that spin time backwards and distort space so that a traveler could go from one universe to another and then another endlessly. In describing all of this the author, the professor of Astronomy at Amherst College, reaches poetic heights, and I have abstracted much from his text in the following summation.

Black Holes

I know no poetry today
That can compare in any way
With the music we hear from the spheres.
Couched, as it is, in such abstract forms
As only Einstein could comprehend
It sings to us of many strange things:
Quasars and quarks, goblins and dwarfs
And awesome black holes that appear
From the ghosts of the frozen stars.
These morbid gaols of gravitation
Wrap themselves around themselves —
 Bending rays of light;
 Warping time and space —
As they crush themselves within themselves
So that beneath a veil of darkness
We may someday find our way
From this our own and native world
To others, and then still others —
Endlessly.
Or travel back a bit in time

To right some wrong we did
Or know again the joys we knew
When we were young.

Matthew E. Morrow, M.D.
St. Augustine

- Dr. Morrow practiced internal medicine in Jacksonville and is now retired and living in St. Augustine. His current book, *Ghosts on the Run*, can be ordered from Merton Press, 604 Atlantic Bank Building, St. Augustine 32084.

Memory fitness over 40

By Robin L. West, Ph.D., 226 pages. Price $14.95. Triad Publishing Company.

What a practical, and yes, reassuring discussion of the changes in memory suspected but not really existing. This scholarly author explains those changes due to disease and those due to inattention and failure to practice stategies for retaining or regaining our ability to remember.

The layman would enjoy the practical clarity of the book and physicians would find it helpful in being able to speak to patients met outside the office.

I am keeping my copy to read again. I need the skills and methods it portrays in such a practical way.

Philip B. Phillips, M.D.
Pensacola

- Dr. Phillips is a practicing psychiatrist in Pensacola.

FLORIDA MEDICAL FOUNDATION
Needs Your HELP!

Please help by buying and encouraging others to buy:

Healthy Florida Citrus
and
Fantastic Florida Pecans

The citrus is available throughout the year and can be mailed directly to your family and friends. The fall pecans will be a definite plus for your holiday baking or your gift list. Both are 25% tax deductible to the donor.

REMEMBER, of all the worthy Auxiliary projects, supporting FMF is the one thing we do for our "own." One of the most important uses of the profits is to support the Impaired Physicians Program.

Please continue to order citrus throughout the year. If you need brochures or order forms, contact your local auxiliary or:

Mrs. Gary M. Wright (Charlotte)
4171 S.E. 38th St. • Ocala, FL 32671
(904) 694-2248 or (904) 732-4032

When You Need Some Special Care, We'll Be There.





In 1927, when Tampa was in need of special medical care, Tampa General Hospital was the first modern medical center to be there. We began a tradition of commitment and concern. Commitment to high standards of medical practice and treatment, and personal concern for each patient.

Today, Tampa General reaffirms that commitment. By expanding our facilities with two patient care towers, we are moving forward to meet the many health care needs of our community well into the next decade.

But most importantly, we're keeping faith with a tradition that individual personalized care is still the best medicine.

With us it always has been... and always will be.

The Tampa General Hospital
Davis Islands • Tampa, Florida 33606 • (813) 253-0711

YOUR NEW LOW DAILY RATES AT AVIS START AT $33.00



Avis features GM cars. Buick Century.

Your association membership means new, uniform low flat rates at Avis. And there's no charge for mileage. Choose from subcompact through full size 4-door car groups:

DAILY RATE	
SUBCOMPACT (Chevrolet Chevette or similar)	**$33.00**
FULL SIZE 2-DOOR (Buick Century or similar)	**$39.00**

These uniform low flat rates make it easy to know your rate before you go. To reserve a car, call Avis toll free: ***1-800-331-1212***

Be sure to mention your Avis Worldwide Discount number: **A/A616900.**

AVIS ***WE TRY HARDER.***®

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. Flat rates are nondiscountable and are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. An additional charge per day will apply in certain locations including Newark Airport, NJ; LaGuardia Airport, NY; Kennedy Airport, NY; and all Manhattan locations. Check with Avis for the amount. Rates, discounts and additional charges subject to change without notice. Cars must be returned to rental location or higher daily rate and a one-way service fee will apply. Cars and particular car groups subject to availability. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

© 1985 Avis Rent A Car System, Inc., Avis®

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

What is Doctors' Day and why observe it?

Eudora Brown Almond, a Georgia Auxilian, originated the idea of having a Doctors' Day because she felt that medicine was the greatest profession on earth and doctors the greatest heroes. This respect and appreciation for the medical profession inspired her to present her idea to the Barrow County Medical Society Auxiliary. Her suggestion was met with approval and the Auxiliary observed the first Doctors' Day on March 30, 1933. This first celebration of Doctors' Day honored the many practitioners of the Medical Arts and set a tradition which is still carried out today.

In the past, Doctors' Day observances included various ceremonies, elegant dinners, toasts and tributes to physicians, city, county, and state proclamations. Today medicine faces numerous changes. Doctors and their families are striving to preserve a healthy image. It is time to show our dedication to good health and to good medicine in other ways. Consequently, in recent years the focus of observing Doctors' Day has turned toward community service. Each community should feel the impact of Auxiliary contributions and know that the medical profession feels a genuine concern for everyone. Now, we stress giving community service in honor of the medical profession. Auxiliaries in sixteen Southern states and the District of Columbia participate in a variety of Doctors' Day activities. A number of other states and jurisdictions have also begun to recognize physicians with observances of Doctors' Day.

Here in Florida, we can be proud of our multiple blood drives, abundant tree plantings, innumerable scholarships, and extremely generous donations of time and money for the betterment of our local communities. In a county-wide blood drive sponsored by the Polk County Medical Association Auxiliary over 556 pints of blood were donated last year. Each donor received a T-Shirt imprinted with the logo, "I Gave a Gift From the Heart."

The Pinellas County Medical Association Auxiliary sponsored their fourth annual blood drive last year with the theme of "Good to the Last Drop." Their collective total to date is approximately 4000 pints of blood donated for the health of their communities. This way of honoring their physicians with a very special "Thank You" was heard and shared by all.

March 30th was selected as the date for Doctors' Day because it was on that day the famous Georgian, Crawford Williamson Long, M.D., first used ether anesthesia in surgery and forever changed the course of medical treatment. This milestone in medical history has marked Dr. Long as one of the greatest benefactors to suffering humanity. His statue is located in the hall leading to the Senate Wing of the Capitol in Washington, D.C., in his honor and memory as the "discoverer of the anesthetic powers of ether in surgery, 1815-1878."

On March 30, 1842, twenty-six old Dr. Crawford Williamson long, who had been practicing medicine less than a year, administered sulphuric ether in a surgical operation for the first time in medical history. The patient was James M. Venable. He inhaled the ether during the entire time of the operation to remove a tumor on the back of his neck. Mr. Venable experienced no pain and was incredulous when shown the tumor that had been removed.[1]

Dr. Long was an honor to his profession. The practice of medicine today is still the most admirable profession in the world, and Doctors' Day is a fitting tribute to those who spend their lives in service to mankind.

Mrs. S. Bruce (Priscilla) Gerber
Winter Haven

1. History and Handbook of Doctors' Day, Southern Medical Association Auxiliary, revised 1980, Birmingham, Alabama.

A WORD TO THE WHYS

WHY AMA?

The AMA actively works to represent your interests by fostering legislation that is beneficial both to the medical profession and the public. Each year the AMA makes thousands of contacts with members of congress and their staffs and frequently translates Association policies into model or draft legislation for governmental action. Active representation of organized medicine: it's one more good reason why you should be part of the AMA.

WHY AMA? Today you can have instant access to a broad range of up-to-the-minute clinical information and protocols for use in patient care through the Medical Information Network. This nationwide, computerized system was developed by the AMA, with General Telephone and Electronics (GTE), to provide you with the most advanced, current scientific information. It's one more reason why you should be a part of the AMA.

WHY AMA? Residents and medical students now have a strong voice in organized medicine. Through the Resident Physician Section and the Medical Student Section, these two groups participate in the policy making process of the AMA and communicate their concerns. Developing future leadership in organized medicine: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

THE APPROPRIATE GIFT FOR
AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

City & State _____

Dr. _____

Street _____

City & State _____

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

APRIL

Critical Care Medicine, April 1-5, Hotel Royal Plaza, Lake Buena Vista. Call: Alan Varraux, (305) 841-5144.

Radiology of Hepatobiliary and Pancreatic Disease: Imaging and Intervention, April 1-5, Miami Hyatt Regency, Miami. Contact: Jill Nolden, Division of Diagnostic Radiology, P.O. Box 016960, Miami, 33101, (305) 549-6894.

Issues and Advances in Pediatrics, April 2-4, Sheraton Sand Key Resort, Clearwater Beach. Contact: Lewis A. Barness, M.D., 12901 N. 30th Street, Box 15C2, Tampa, FL 33612-4799.

Fourth Annual Interventional Radiology Seminar, April 2-5, Palace Hotel, Lake Buena Vista. Contact: Martin Selbiger, M.D., (813) 974-2538.

New Approaches to Common Disorders, April 3-5, Adams Mark Resort, Clearwater. Contact: Joel Gleason, M.D., USF College of Medicine, (813) 397-5511.

Regional Cancer Conference, April 8-11, Lake Buena Vista, Lake Buena Vista. Call: Clarence Brown, M.D., (305) 841-5144.

Forty-First Regional Family Practice Weekend, April 11-13, Lincoln Hotel, Tampa. Contact: Robert L. Dawson, M.D., 4057 Carmichael Ave., #229, Jacksonville 32207, (904) 398-5667.

Orthopedics for the Family Practitioner, April 13-18, Sonesta Village, Orlando. Contact: Irving Raphael, M.D., P.O. Box 725, Syracuse, New York 13210, (315) 470-7838.

1986 Radiation Therapy Seminar, April 17-19, University Centre Hotel, Gainesville. Contact: Division of Radiation Therapy, JHMHC J-385, Gainesville, 32610.

Why, How and When — Flexible Sigmoidoscopy, April 19-20 and November 15-16, Sonesta Beach Hotel, Key Biscayne. Contact: John P. Christie, M.D., 6614 Miami Lakes Drive East, Miami Lakes, Florida 33014, (305) 687-1367.

Clinical Virology Seminars, April 21-23, Holiday Inn Surfside, Clearwater. Contact: Steven Specter, Ph.D., USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 974-2178.

Physiology of Fitness, April 22-26, Sonesta Village Hotel, Orlando. For more info: Alan Varraux, M.D., (305) 841-5144.

Consideration in the Selection of Antimicrobial Therapy, April 28, Doctors Memorial Hospital, Perry. Contact: I. B. Harrison, M.D., (904) 681-5121.

MAY

Five-Day Diabetes Management Course, May 12-16, USF College of Medicine, Tampa. Call: Anthony Morrison, (813) 974-4360.

Pediatrics for the Practitioner, May 16, Bay Harbor Inn, Tampa. Contact: Lewis A. Barness, M.D., 12901 North 30th Street, Tampa, FL 33612, (813) 974-4214.

Master Approach to Cardiovascular Problems, May 24-26, Contemporary Hotel, Lake Buena Vista. Contact: Augustin Castellanos, M.D., P.O. Box 016960 (D-39), Miami, FL 33101, (305) 549-7124.

JUNE

Seventh Annual Child Neurology Postgraduate Course, June 9-12, Sonesta Beach Hotel, Key Biscayne. Contact: Oscar Papazian, M.D., 6125, S.W. 31st Street, Miami, FL 33155.

Florida Suncoast Pediatric Conference 1986, June 14-18, Trade Winds Resort, St. Petersburg. Contact: Gilbert Pitisci, M.D., 2506 West Ave., Tampa, Florida 33607, (813) 870-8720.

FAFP 37th Annual Scientific Assembly, June 26-29, Marriott's Marco Beach Resort, Marco Island. Contact: Martha Moores, 4057 Carmichael Avenue, Suite 229, Jacksonville, Florida 32207, (904) 398-5667.

Coronary Heart Disease, July 18-19, Dutch American Hotel, Orlando. Contact: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

AUGUST

Strategic and Operational Survival Plans for Office Based Physicians, August 22-24, Orlando Hyatt Hotel, Orlando. Contact: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

ONGOING

Seminars — Most major ski areas, Club Med, Disney World and other resorts. Topic: Medical/Legal and Financial Management. Accredited. Current Concept Seminars, Inc. (since 1980) 3301 Johnson St., Hollywood, FL 33021 (800) 428-6069. Fee $175.



PREGNANT MOTHERS: PLEASE DON'T SMOKE!

Here are three good reasons to quit smoking now:

1 Smoking retards the growth of your baby.

2 Smoking increases infant mortality.

3 Your family needs a healthy mother.

Don't smoke.
For your baby's sake.
And yours.

AMERICAN CANCER SOCIETY

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name:_____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

GENERAL INTERNISTS, THORACIC AND GENERAL SURGERY, DERMATOLOGY, FAMILY PRACTICE, and RADIOLOGY: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

FAMILY PRACTICE opportunity: South Miami area. Board eligible or certified preferred. Excellent pay and working conditions. Affiliated with major medical center. Full or part-time. Respond with C.V. to Box C-1306, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE: Physician needed in expanding 153 bed hospital to manage ICU, surgical and diverse medical patients in correctional setting. Well equipped facility near Gainesville and UF with competitive salary and good benefits. No O.B. or evening/weekend call. Please call John E. Metheny, M.D., at (904) 496-2222, Ext. 121 or send CV to Medical Director, Reception and Medical Center, P.O. Box 628, Lake Butler, Florida 32054.

FAMILY PRACTICE, INTERNAL MEDICINE, EMERGENCY, M.D.'s needed for rapidly expanding network of ambulatory care centers in the Tampa Bay Area of Florida's Gulf Coast. Paid malpractice/competative salary/flexible work schedule/plus generous incentive packages. Please call or respond with CV to: Kendal B. Stiles, M.D., Medical Director, United Gulf Medical Centers, P.O. Box 31272, St. Petersburg, FL 33732. Ph.: (813) 896-2431.

EXCELLENT OPPORTUNITY available for Florida Licensed ophthalmologist to join busy practice in coastal Florida city. Retinal fellowship preferred. Please send curriculum vitae and recent photo to P.O. Box 17125, Jacksonville, FL 32245-7125.

A WEEK, A YEAR, A CAREER — practice opportunities in Jacksonville, Miami, Orlando, Daytona Beach, Tampa. Options for permanent and/or locum tenens placements in all specialties. Trial associations with established practices in a variety of clinical settings. Call Suzanne J. Anderson at 800-833-3465 or write: Medstaff, Inc., P.O. Box 15538, Durham, N.C. 27704.

DIAGNOSTIC RADIOLOGIST North Orlando area — private clnic approximately 15 to 20 hours per week. Flexible arrangement. Reply to C-1323, P.O. Box 2411, Jacksonville, FL 32203.

CARDIOVASCULAR THORACIC SURGEON with Florida license needed to join large fully equipped Clinic serving a rapidly growing West Coast Community. Send CV to P.O. Box 36, New Port Richey, FL 33552.

GP — full/part-time mornings for new, private medical office in Hallandale, Florida. Great opportunity for motivated Dr. Salary + /or partnership, no investment. Call (305) 457-7000/(305) 966-7578.

INTERNIST — Very busy solo general internist on the east coast of Florida looking for an associate. Great opportunity to step into a thriving practice. Call (904) 428-3241 or (904) 427-1301.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

PRIMARY CARE FACILITY in West Palm Beach seeking P/T physicians for hourly work and full time physicians for future facilities. Send CV to P.O. Box 16474, West Palm Beach, FL 33416.

PRIMARY CARE CENTERS IN FLORIDA, NEW YORK, NEW JERSEY: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full time basis. Positions available in Central and South Florida coastal communities, central and northern New Jersey, and Long Island, New York area. Guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 930 South Harbor City Blvd., Suite 307, Melbourne, FL 32901.

INTERNIST with Cardiology and Pulmonary experience needed to join large fully equipped Clinic serving rapidly growing Florida West Coast Community. Must have Florida License. Send CV to P.O. Box 36, New Port Richey, FL 33552.

UROLOGIST — Central Florida — established BC urologist in solo practice near Orlando needs BC/BE urologist associate. First year salary and productivity bonus leading to early partnership. Send CV and resume of medical/urological experience to: Joe Stansell and Associates, P.O. Drawer W, Sanford, FL 32772.

FAMILY PHYSICIAN or general internist to join busy internist in the Florida Keys. Flexible association available. University training preferred. Send CV: R. Carraway, M.D., P.O. Box 2008F, Key West, FL 33040.

ASSISTANT CITY PHYSICIAN position, City of Orlando, Florida, U.S. training in primary care with 1-2 years in either orthopaedic or general surgery. Outpatient adult clinical practice mostly treating occupational injuries and pre-placement physicals. Forty hours 8:00-5:00, Monday-Friday. Excellent fringe benefits. Send curriculum vitae in confidence to Director, P.O. Box 3412, Orlando, FL 32802.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T.C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

TAMPA — Excellent opportunity to become the primary physician of a well-established growth oriented Family Practice in the fastest growing city in the South. Practice benefits include association with a specialty group, computerized management system, X-ray, laboratory, Spirometry, modern offices in pleasant surroundings. We are seeking a Board Certified or Board Eligible Family Practitioner, highly motivated and dedicated to delivery of quality health care. Excellent base salary plus strong incentives based on revenues. We will provide assistance with interview and relocation expense. If you would like to be an important part of our growing

team, send your CV to C-1327, P.O. Box 2411, Jacksonville, FL 32203.

CLINIC PHYSICIAN — Venice, FL. Privately owned walk-in clinic, Florida Medical License, surgical residency required. Duties include examination, diagnosis and treatment of clinic patients, primarily trauma and accident cases. Salary $32 per hour, 40 hour week. Varied schedule including nights and weekends. Apply at Job Service of Florida, 2312 Gulf-to-Bay Blvd., Clearwater, Florida 33575-8696. Job order #4464462. EOE M/F/H/V.

THE VETERANS ADMINISTRATION, Medical Center, Lake City, Florida, is recruiting for a board certified Anesthesiologist. Potential academic appointment at University of Florida. Affiliation in surgery with the University of Florida. Competitive salary plus incentive pay commensurate with qualifications. Liberal benefits plus malpractice insurance and retirement program. The North Florida area offers an excellent climate year round, extensive outdoor recreational activities, lower than average cost of living, fine schools and nearby university, local community college, uncongested commuting to and from the Medical Center. Contact John H. Beggs, M.D., Chief of Staff, VA Medical Center, Lake City, FL 32055, (904) 755-3016, Ext. 2011. An Equal Opportunity Employer.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4204.

ESTABLISHED WALK-IN CLINICS — Sarasota Co. Well qualified M.D.'s with primary care background. Excellent working conditions. Pay and incentives according to qualifications. Send CV to T.M. McNaughton, M.D., 540 S. Nokomis Avenue, Venice, FL 33595 or call (813) 484-2167.

TWO POSITIONS AVAILABLE immediately. Excellent opportunity for Family practitioner/Internist. BC/BE in west coast Florida. Immediate appointment with excellent salary, benefits and profit sharing. Reply in confidence to Oneco Medical Center, Attn. B.A. Hooli, P.O. Box 1486, Oneco, FL 34264.

ORLANDO — Physician needed for freestanding ambulatory care center. Competative hourly wage with incentive bonus. Contact Fran Olschner, BVL Family Medical Center, 2531 Boggy Creek Rd., Kissimmee, FL 32743. Phone 305/933-0990 or 305/422-0430.

OB-GYN needed for multi-specialty group; university town in Northwest Tennessee; excellent, fully equipped hospital, JCAH accredited, HCA affiliate. Contact: Joe D. DePew, Administrator, Volunteer General Hospital, P.O. Box 828, Martin, TN, 38237, (901) 587-4261.

Situations Wanted

LOCUM-TENENS: RADIOLOGIST, Board Certified, university trained with academic background, age 47, experienced in most modalities, will consider office and/or hospital-based practice. Please write C-1311, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST completing sub-specialty fellowship in pulmonary medicine July 1, 1986 seeking academic and clinical practice group for affiliation. CV, recommendations, etc. on request. Please respond to Warren S. Goff, D.O., 21631 Jacksonville Road, Farmington Hills, Mi. 48027, phone 313-474-4414.

PHYSICIAN ASSISTANT: Board certified, 36, 7 years experience in family practice and acute care. Personable, enthusiastic, motivated. Practice management skills. Guaranteed to build practice, increase net income. $175K/yr. ave. gross. Reg. salary pkg. with equity sharing. Prefer coastal S.E. U.S., private sector. Robert White, PA-C, 4214 Redwood Ave., Jacksonville, FL 32207, (904) 731-9079.

PULMONOLOGIST: Will complete fellowship at the University of Kentucky in July of 1986. Looking to locate in Florida. Licensed in Texas and Kentucky. Contact: Jerry Sampson, M.D., 2080 Regency, Lexington, KY 40503, (606) 277-3711.

EXPERIENCED F.P., Board Recertified, Fellow AAFP, Florida licensed, wants association, partnership or a practice in Florida. C-1319, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE PHYSICIAN: Board Certified, Florida licensed; extensive academic and practice experience; seeking association with solo or group practitioners or academic position full or part time; available July 1986; West Palm Beach or vicinity only! Edward H. Davis, M.D., 315 Beach 143 Street, Neponsit, NY 11694.

FMG, ABIM, Gastroenterologist — University trained. Seeking practice opportunity in solo or group in Florida and South East United States, starting July 1986. Would consider other locations. C-1326, P.O. Box 2411, Jacksonville, FL 32203.

LOCUM TENENS: Board Certified anesthesiologist: 30+ years experience. Florida license, malpractice coverage. Call (904) 799-3104 or (904) 596-0729.

BOARD CERTIFIED INTERNIST with specialized training in geriatrics seeks group/solo practice opportunities. Florida licensed with excellent credentials. Available July 1986. C-1324, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

RETIREMENT MINDED OB-GYN in north Florida looking for partner in practice grossing 400,000 t. Partnership immediately with transfer of practice in two years. C-1316, P.O. Box 2411, Jacksonville, FL 32203.

RICHARD LEFFERT, DDS, Associate Executive Real Estate, Inc., specializing in Professional Practice Sales & Marketing. 1715 Stickney Point Rd., Suite A, Sarasota, FL 33581, (813) 924-1231 after hours (813) 922-6161.

ESTABLISHED PREVENTIVE MEDICINE and General Practice in Greater Orlando. $29,000 with equipment; willing to introduce to patients and hospital staff; call evenings (305) 886-5361 or write C-1313, P.O. Box 2411, Jacksonville, FL 32203.

FLORIDA WEST COAST: Splendidly located, freestanding clinic for family practice or walk-in. Laboratory and x-ray. Rapidly expanding community. Nearby accredited hospital. Annual gross over 400,000.00. C-1321, P.O. Box 2411, Jacksonville, FL 32203.

BEAUTIFUL LAKELAND, FL: Solo family practice and 1,876 square foot office, furnishings and equipment. Four examining rooms, x-ray, lab, EKG, efficiency apartment. Seven hundred bed open staff hospital. Phone 1-813-646-2734.

FAMILY PRACTICE for sale in beautiful Jupiter area. Condo office, equipped, nice. Ideal for F.P. or I.M. Good income. Must retire, health reasons. Two good hospitals, require BE or BC. (305) 747-0279, after 7 p.m. please.

FOR SALE: OB/GYN practice. Physician retiring. Last year grossed $170,000, which could be doubled. Office located next to hospital. All modern equipment. N.C. malpractice insurance is $14,000. Call afternoons (919) 892-4131.

PSYCHIATRIST with psychoanalytic orientation and forensic subspecialty seeks associate, new or established M.D., board certified or eligible, with FL license to join and/or buy established 13 year psychiatric practice, located in metropolitan Tampa Bay area. Willing to consider creative options with view toward retirement. Terms flexible, negotiable. Dr. P. Callahan, P.O.B. 1686, Largo, FL 34294. (813) 584-4275 24 hrs.

PEDIATRIC PRACTICE: (BCBE) in rapid growth area of Central Florida. Busy, well established, fully equipped practice. Terms negotiable, will introduce. Fla. license. C-1325, P.O. Box 2411, Jacksonville, FL 32203.

PRACTICE FOR SALE: Excellent opportunity for GP in Miami. 15 years established. Centric location near hospitals. Fully equipped. 9 to 5: (305) 642-4366, evenings: (305) 531-3684.

Real Estate

SPRING HILL, FL — 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease — owner will finance. (904) 596-4162 weekdays.

DOCTOR MUST SELL new luxury prime condo, Park Plaza, 12th Floor. 3 bedroom, 2 bath. Covered parking, pool, magnificent view St. John's River and downtown Jacksonville. Dock available. Below market. Phone (305) 278-1067.

PHYSICIAN OWNER MUST SELL new fully furnished ocean front condo at Seawatch (Vilano Beach). On ocean, pool, tennis, covered parking. 2 bedroom, 2 bath. Below market. Phone (305) 278-1063.

SHARE MEDICAL-SURGICAL office 5½ days, 1500 E. Hillsboro Blvd., Deerfield Bch. FL 33441. 3 exam rooms, lab, and business office. Patrick E. Callaghan, M.D. (305) 428-2420.

UNIQUE FRANCHISE available to physicians and dentists only. For information call Bob Richardson (305)977-9322.

NURSING HOMES and adult congregate living facilities — limited partnerships. Earn over 16%. Life Care Retirement Facilities, Inc. Contact: Milton — (305) 751-0831.

PROFESSIONAL OFFICE SPACE — Prestigious community of Sarasota. 1600 Sq. Ft. Previous tenant busy M.D. Turn key ready. (813) 921-5521 or (813) 923-7103.

MEDICAL OFFICE SPACE 917 to 3339 sq. ft. New prestigious building with outstanding visibility. Three blocks from hospital. Sale or Lease (813) 649-4666 Naples, FL 33940.

SACRIFICE — Lakefront house, Avon Park-Lake Verona. 3-2, two-story, chimney-fireplace, 44 ft. screened patio; good swimming, near always-open tennis courts. 10½% mortgage. (305) 836-0300.

COLORADO — Picturesque mountain ranch home for rent. Comfortable any season. All outdoor activities. Adjacent wilderness area. Also 3 lovely building sites available. Brochure. Thomas Beach, M.D., (904) 387-7300.

INVEST IN THE FUTURE: Invest in Florida. Let us list or locate for you with confidence and personal attention. Commercial — Acreage — Farms. Greg Martin Real Estate, Inc., P.O. Box 2445, Belleview, FL 32620. (904) 245-9113.

FOR LEASE: This beautiful 1,000 sq. ft. of office space is located on the ground floor at two very busy intersections in a Condo area. Broward County. Fantastic exposure. Low rent. Will be available in the Spring 1986. Phone 1-800-533-5564.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and reconditioned Holter-Stress-Echo-EKG and other medical Electronic Instruments. Contact Ed Bentolila, P.O. Box 8676, Coral Springs, FL f33065, (305) 972-4600.

Meetings

BIOFEEDBACK THERAPIST TRAINING PROGRAM — Six day program (2-3 day weekends) to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. CEU's Available. Jan. 17-19 & Jan. 24-26, or March 1-3 & March 15-17, or May 16-18 & May 30-June 1, or July 11-13 & July 25-27, 1986. For brochure contact: Hartje Stress Clinic, 2429 University Blvd., West., Jacksonville, FL 32217. (904) 737-5821.

1986 CME CRUISE/CONFERENCES ON selected medical topics — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-12 days yearround. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) & AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican, Mediterranean, Alaskan cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

CONTROVERSIES IN TRAUMA MANAGEMENT, April 18-19, 1986, Miami, Florida. Credit: 10 CEU's, fee: $225.00 physicians, $150.00 paraprofessionals and RN's. Contact: Ms. Kara Atchison, UM/JM Medical Center, P.O. Box 016960 (D-40), Miami, Florida 33101.

MAY 1-4, FLORIDA SPEECH, Language, and Hearing Association (FLASHA) Spring Convention, Jacksonville, Florida. Contact: Tim Stavropulos, 5720-1 Atlantic Boulevard, Jacksonville, Fl. 32207. (904) 725-4646. ASHA continuing education credits available.

Equipment

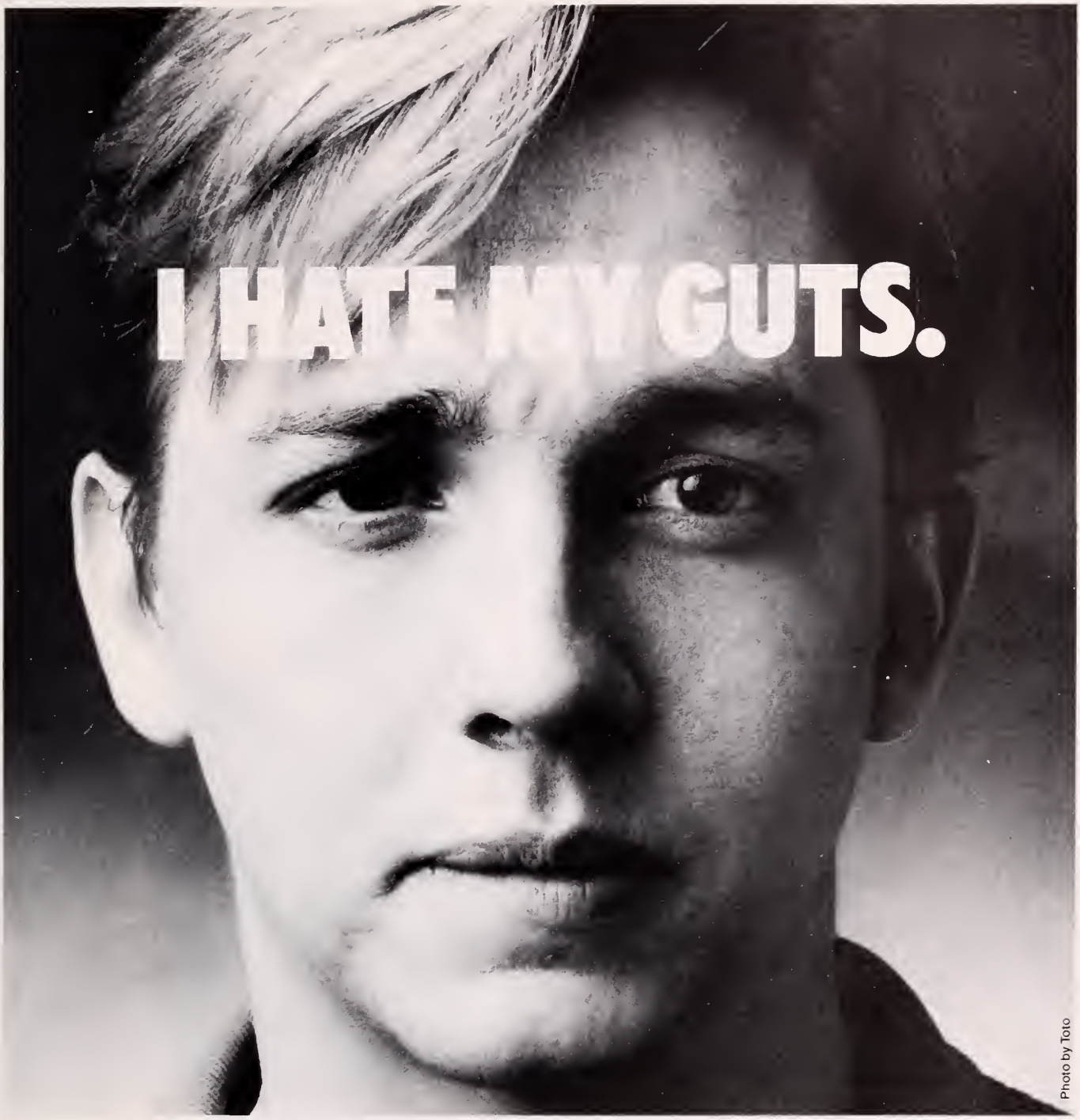
XEROX 125 MAMMOGRAPHY processing system. Currently in use in Jacksonville, under Xerox service contract. Available for sale in May for $7000. Phone (904) 398-1977.

FOR SALE: 4700 A, H. P. Cardiograph page writer with cart, 1985 Model. Contact Lawson C. Johnson, M.D., 2250 South Dixie Hwy., Miami 33133, 305-856-5170.



Make sure the tax shelter you choose is *legal* — you're responsible for penalties, interest, *and* taxes if it's *illegal*.

A public service message from the IRS



You've had painful stomach cramps before. And terrible diarrhea. Can you imagine what it would be like to live with those symptoms forever?

Well, when you have Ileitis or Ulcerative Colitis, it's like having a stomachache that never goes away.

Over 2 million men, women, and children suffer from these devastating intestinal diseases. That's more victims than Muscular Dystrophy and Cerebral Palsy combined.

For each of them life can mean constant pain, anguish and embarrassment.

Yet as widespread as Ileitis and Ulcerative Colitis are, they're just as misunderstood.

Some people think these diseases are only in your mind. They're not.

Some people think they come from eating the wrong kinds of foods. They don't.

Some people even laugh at the symptoms. They shouldn't. Because Ileitis and Ulcerative Colitis can strike you at any age, at any time. They can put you in the hospital for weeks, even months. And there's no known cause. Or cure.

Please help us in the fight against Ileitis and Ulcerative Colitis. We need to find a cure. And we need to put an end to harmful misconceptions.

Because when you have a disease that many people acknowledge with only snickers and whispers, it's easy to mistakenly begin hating yourself as much as you hate your disease.

The National Foundation for
Ileitis & Colitis

To send your tax-deductible contribution or for more information, please write:
N.F.I.C., P.O. Box 2020, Murray Hill Station, New York, NY 10156



A Kiss Can Save A Life

When you kiss your child, you give and receive love. But your kiss could also be a test for cystic fibrosis, an inherited respiratory and digestive disease. An excessively salty taste to the skin is one symptom of cystic fibrosis. Call your doctor or local Cystic Fibrosis Foundation Chapter for more information. Early diagnosis and treatment can be the key to a better quality of life for CF children.

Meantime, kiss your baby. It's a good idea, anyway.

Bernard Bragg has won critical acclaim as an actor. He has never heard applause.



PHOTO ERNESTO BAZAN

Bernard Bragg is a co-founder of The National Theatre of the Deaf. He has performed on television and Broadway and was an artist-in-residence at the Moscow Theatre of Mimicry and Gesture. He has studied under Marcel Marceau and taught workshops at Harvard University.

Believe in them. Break the barriers.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, WASHINGTON D.C. 20210

PRODUCED BY THE SCHOOL OF VISUAL ARTS PRESS, LTD.

ADVERTISERS

Air Force
Recruitment 166

Army Reserves
Recruitment 230

Burroughs Wellcome Co.
Wellbutrin 159a

Brown Pharmaceutical
Android 166
Lipo-Nicin 213

Curtis 1000 Information Systems
Computers 184

Eli Lilly & Company
Keflex 230a

E.R. Squibb and Sons, Inc.
Corzide 159

Florida Army National Guard
Recruitment 219

Florida Physicians Insurance Company
Service 158

GTE Telenet
Service 178

Info Systems
Computers 122

Knoll Pharmaceutical Company
Isoptin 230b
Vecodin 158b

Lucerne Spinal Injury Center
Health Care Witness Conference 167

Marion Laboratories, Inc.
Cardizem 230e

Medical Education Foundation of Miami
Meeting 214

The Physician and Sportsmedicine
Publication 214

Roche Products, Inc.
Dalmane 247

Shari Medical Center
Recruitment 163

Smith Kline & French Laboratories
Dyazide 158c

The Tampa General Hospital
Service 233

University of Alabama
Service 176

University of Miami
Meeting 195, 213

Upjohn Company
Motrin 158d

Willingway Hospital
Service 230

Wyeth Laboratories
Ativan 167

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

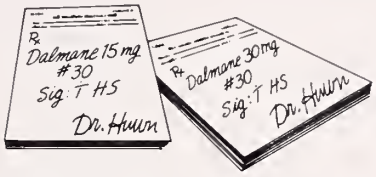
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
flurazepam HCl/Roche Ⓥ
sleep that satisfies

15-mg/30-mg capsules



References: **1.** Koles J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al. Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD. *J Clin Psychopharmacol 3* 140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treotment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mor 1977.



DALMANE®
flurozepam HCl/Roche Ⓥ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling osleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurozepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurozepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.* excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see references ond summory of product informotion on reverse side

DALMANE®
flurazepam HCl/Roche ⓒ IV
sleep that satisfies



C01183 0C
COLL.OF PHYS PHILADELPHIA
LIBRARY
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

ROCHE®

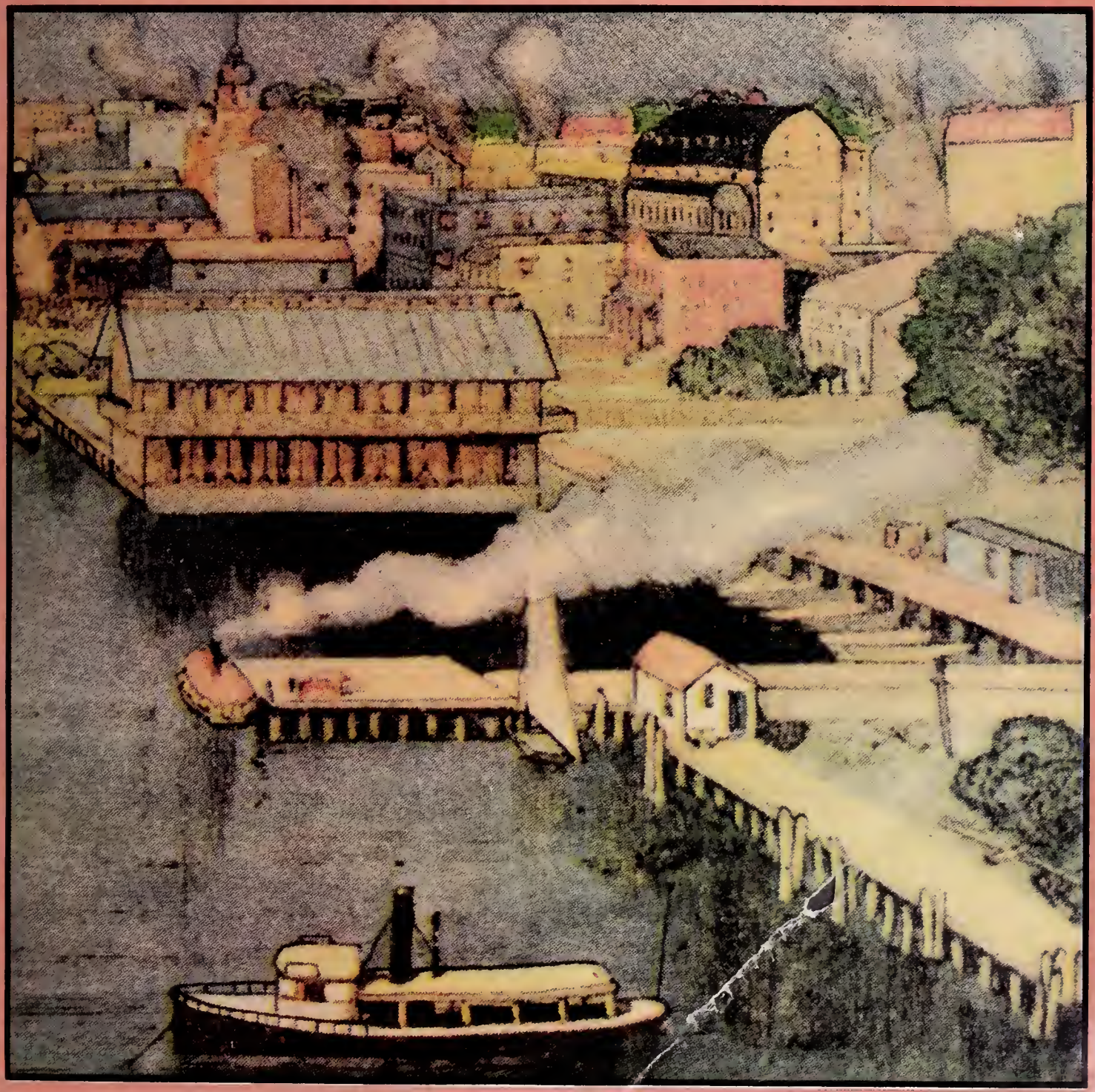
Copyright © 1985 by Roche Products Inc. All rights reserved.

STACKS

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. April 1986, Vol. 73, No. 4

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
MAY 9 - 1986
M. D. S.

HISTORICAL ISSUE



Announcing

NEW $250,000 / $750,000 COVERAGE LIMITS.

This new limit is now available to assist physicians who have expressed a desire for reduced coverage.

FPIC will continue to offer all coverage limits previously available as listed below:

$ 500,000 / $1,500,000
$1,000,000 / $3,000,000
$1,500,000 / $4,500,000

FPIC continues to meet the needs of Florida Physicians.

FPIC is the only FMA sponsored plan for professional liability coverage.

For more information call Ron Gladman:

FPIC FLORIDA PHYSICIANS INSURANCE COMPANY

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

Motrin® 800 mg TABLETS
ibuprofen



Extra strength
Convenience
Economy

Upjohn
A Century of Caring
1886·1986

©1986 The Upjohn Company

J-6138 January 1986

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

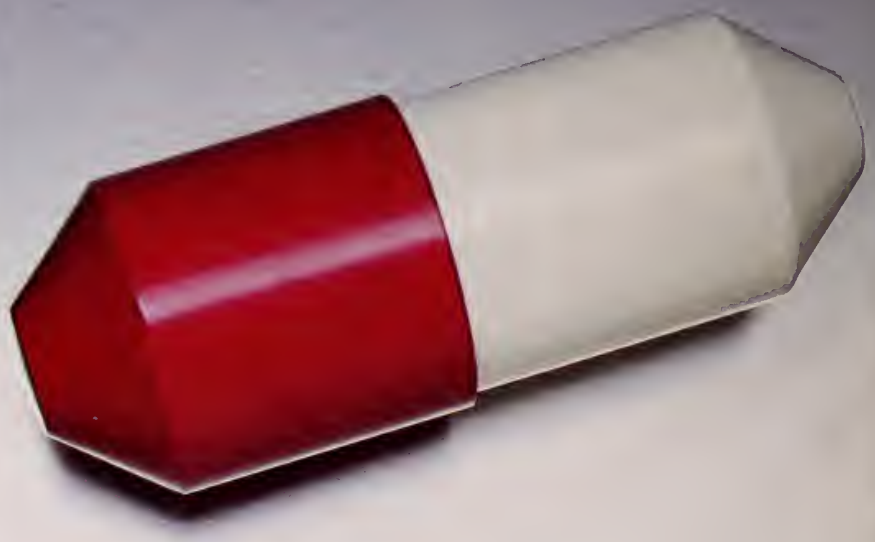
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ-L39

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions)



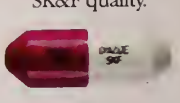
Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 19 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.



a product of

SK&F CO.

Carolina, P.R. 00630

©SK&F Co., 1983



To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
with acetaminophen 500 mg

Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetominophen or hydrocodone.
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III) Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex, caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus
Usage in Pregnancy: Pregnancy Category C Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur, they are more frequent in ambulatory than in recumbent patients Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required

Revised, April 1982

5725

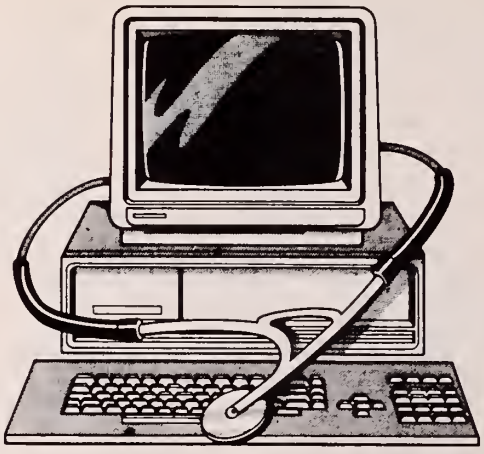
knoll® KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

February, 1985

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345



A ready reference for much of the information you need

Advances in medicine are rapid, and keeping pace poses quite a challenge. Yet, access to and understanding of current knowledge on therapies and medications are absolutely necessary to function in today's competitive environment.

Searle professional medical sales representatives, like Carolina Camps of Miami, Florida, serve you in this effort. They represent a line of trusted products as well as a source of vital, up-to-date information required by your medical practice.

When you have a question about the latest pharmaceutical developments relating to Searle products, call your Searle professional medical sales representative for the information you need, when you need it.

The physicians of Florida and Searle—a union of caring, a future of promise.

SEARLE *Searle Pharmaceuticals Inc.*
Box 5110, Chicago, IL 60680

2/86 • 59044T

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

- —drug and disease information
- —clinical abstracts
- —administrative and medical-practice information
- —Continuing Medical Education courses
- —Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC.
P.O. BOX 2411, JACKSONVILLE, FL 32203
TELEPHONE 904/356-1571

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

AMERICAN MEDICAL INTERNATIONAL'S PHYSICIAN PLACEMENT SERVICE



American Medical International has instituted a new corporate service to assist Physicians interested in solo or group practice opportunities servicing AMI hospitals. Current opportunities are available for physicians who are Board Certified or Eligible. Specific areas of interest are:

- **Allergist**
- **Anesthesiologist**
- **Cardiologist**
- **ENT**
- **Emergency Medicine**
- **Family Practice**
- **Gastroenterologist**
- **General Practice**
- **General Surgeon**
- **Geriatric Medicine**
- **Industrial Medicine**
- **Neurologist**
- **Neurosurgeon**
- **OB/GYN**
- **Ophthalmologist**
- **Orthopedic Surgeon**
- **Pediatrician**
- **Plastic Surgeon**
- **Radiologist**
- **Rheumatologist**
- **Thoracic Surgeon**
- **Oncologist - Medical and GYN**

Physicians interested in pursuing opportunities with AMI should contact this service by calling or submitting a curriculum vitae to:

Norman Penick
Vice President
Human Resources
AMI
9465 Wilshire Blvd., Ste. 915
Beverly Hills, CA 90212
(213) 858-6927
National (800) 533-7013
California (800) 325-4881

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

APRIL 1986, Vol. 73, No. 4

CONTENTS

HISTORICAL ARTICLES

James T. Howell, M.D., M.P.H.	**273**	Guest comments — *JFMA* historical issue
H. Frank Farmer Jr., M.D., Ph.D.	**274**	Our debt to public health
C. L. Brumback, M.D.	**276**	A local public health experience — history of the Palm Beach County Health Department
E. Russell Jackson Jr., M.A., M.P.H.	**280**	Indigent care and public health in Florida, 1931-1985
David L. Crane, M.D.	**286**	Development of the Florida County Public Health Unit System
William M. Straight, M.D.	**289**	The great typhoid epidemic in Florida, 1898
H. Frank Farmer Jr., M.D., Ph.D.	**300**	Hookworm eradication program of Florida in the early 20th century
L.C. Manni, M.D.	**305**	History of Tuberculosis in Florida
John Andrew Mulrennan Jr., Ph.D.	**310**	Mosquito control — its impact on the growth and development of Florida
David P. Adams	**312**	The best of both worlds: general practice in rural Florida, 1928-1950
Robert D. May, M.D.	**317**	Who killed Cock Robin?
William W. Cox, M.D.	**321**	Our medical heritage — a synopsis of the discipline of medical practice in Florida

COVER

This month's cover of *The Journal* is a portion of a drawing that was featured in *The Florida Times-Union* special section on "Crowning a Century in Florida," Sunday, December 27, 1964. The artist was Shirrel Rhoades.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.* [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc., are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Florida Medical Association, Inc.

DEPARTMENTS

257 President's Page
Unity is the key

261 Editorials
Liability reform: it is now the Legislature's move
R.G. Lacsamana, M.D.
Turning the CME corner
Robert C. Fore, Ed.D.

267 Letters and Viewpoints

329 Medical Economics
The elements of power
Jacques R. Caldwell, M.D.
A reply to Dr. Caldwell
Arthur L. Hall, M.D.
Dr. Caldwell's reply
Jacques R. Caldwell, M.D.

337 Notes & News

338 Dean's Message

339 Encores!

343 Correction

345 FMA Auxiliary
Missing children posters program started
Mrs. W. Jackson (Elaine) Dickens

348 Meetings

350 Classified Advertising

354 Index to Advertisers

354 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

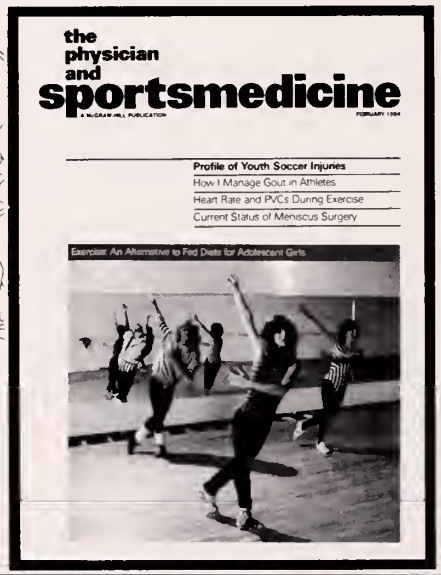
Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Karl Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.

OVER 66,000 FAMILY PHYSICIANS READ THIS JOURNAL





Practical information on the medical aspects of fitness and exercise.

Tennis elbow: Joint resolution by conservative treatment.

Hypertrophic cardiomyopathy and the athlete.

Effects of sunscreen use during exercise in the heat.

Overuse injuries to the knee in runners.

How I manage ingrown toenails.

Mc Graw Hill

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg



Unity is the key



When I assumed office as your President in May 1985, I issued to each of you a call for unity and working together for a new beginning and direction for the Florida Medical Association on behalf of the physicians of Florida and their patients. During the past year, we have worked hard to achieve that goal; and I feel that we have had many successes. Our greatest achievement was the Assembly for Liability Reform held in Tallahassee on Monday, April 21. Never before have physicians come together in such a single voice and unified effort to achieve a common goal. This unity was shared with representatives from 76 other organizations representing thousands of Floridians who are being affected by the liability crisis in our state.

The Assembly can be described as nothing less than a total success thanks to the outstanding cooperation received from component county medical societies and specialty groups of the FMA and the many associations who share membership in the Florida Coalition for Liability Reform. Between 3,500 and 4,000 people from all areas of the state participated. It was a record crowd that went to Tallahassee to talk to legislators about the need for tort reform during the 1986 session of the Legislature to resolve this crisis that is having devastating effects on all segments of our society.

You can be proud of your actions and your personal commitment to this important effort. You can also feel confident that the Legislature will listen and steps will be taken to resolve this crisis. However, we must be cautious not to consider Monday's Assembly as the job done. Our efforts must only increase as we enter the crucial weeks ahead. During this time the bills we have proposed (HB627 and SB977) that place a cap on noneconomic damages in the amount of $250,000 will be debated in the committees of jurisdiction in the House and Senate. We must continue to lend our complete support when called upon to testify or make important contacts with legislators regarding this issue. We must be in Tallahassee as often as possible, and we must encourage our patients as well as our friends in the business community to let their feelings regarding this issue be known to their legislators.

We have the best opportunity ever to resolve this problem once and for all, and I have no doubt that we can be successful through a continuing, unified voice. Moreover, it is my sincerest hope that this same spirit of unity and cooperation will carry forward into the future as we address the many other crucial problems facing medicine in our state. We have truly taken a step in the right direction in resolving the professional liability crisis, and we have truly established a new beginning and a new direction for the Florida Medical Association.





The panel spoke on the liability crisis before the luncheon. From left to right: Win Froelich, M.D., U.S. Senate Labor and Human Resources Staff; Luis M. Perez, M.D., FCLR Vice Chairman; Donald C. Jones, FCLR Assistant Treasurer; Fred Hagan, FCLR Chairman; Bruce Martin, FCLR Secretary-Treasurer; Scotty Fraser, Associate Executive Director for Legislation and Public Affairs; Buddy McCue, Vice President and Director of Industry Relations and Legislation of the Florida Insurance Agents Association; and Senator Dempsey Barron.



Members of the coalition filled the auditorium to listen the panel.

"A DAY IN THE Assembly for

The Assembly for Liability Reform held in Tallahassee on Monday, April 21, sponsored by the Florida Coalition for Liability Reform, was by all measures a tremendous success in bringing to the attention of the Legislature the severity of the professional liability crisis in Florida. Between 3,500 and



More than 3,000 participants marched to the Capitol to show their support for liability reform.



Luis M. Perez, M.D., FMA President addressed the Assembly while (left to right) Donald C. Jones, FMA Executive Vice President and Fred Hagan, Executive Vice President of the Florida Independent Automobile Dealers Association looked on.

RIGHT DIRECTION" Liability Reform

4,000 representatives of the 77 member organizations of the Coalition attended. It was the largest group assembly ever held in Tallahassee. Complete details regarding the Assembly will be published in the April issue of "FMA Today."



A steady flow of supporters headed to the Capitol.



The Exhibit Hall of the Tallahassee-Leon County Civic Center was packed for the luncheon held before the march.



MEDICAL STAFF DECISION-MAKING

Hospital Medical Staff Section
Seventh Assembly Meeting

JUNE 12-16, 1986

HYATT REGENCY HOTEL
CHICAGO

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
Phone (312) 645-4747 or 645-4753

Liability reform: it is now the Legislature's move

The assembly in Tallahassee on April 21 by members of the Florida Coalition for Liability Reform symbolized the united front of a movement that is sweeping not only through Florida, but across the entire nation as well. The message rings loud and clear: the Legislature must come up with long-overdue reforms, or the alternative is a system that will continue to grip and paralyze us all.

Physicians for years have been warning about an impending liability crisis propelled by an escalating number of lawsuits and soaring, often exorbitant malpractice premiums. Very few people listened, preferring to believe that the problem was a domestic quarrel between physicians and lawyers. But there has been a dramatic shift in public attitude since then. Just about anybody dispensing a service or manufacturing a product has found himself victimized by either non-existent liability coverage or excessively priced premiums. Even Uncle Sam, who has the deepest pocket among us all, is starting to feel the bite. President Reagan, after a task force concluded that there is a liability crisis, recently announced proposals to seek relief for the federal government from a system that has gone berserk.

More important, the public has been aroused and now is more well-informed about what has been happening. The standard daily fare on TV and in the printed media recounts to millions of Americans the endless merry-go-round of litigations, the almost incomprehensible awards being handed out by juries and judges, the bizarre distortions of the law and common sense where people with no grounds to sue can still go to court and win hefty amounts of money, and the arrogance of trial lawyers who cannot imagine that the current system can ever be at fault for what is taking place.

Sure there are misfits and incompetents in every trade and profession who can harm the public. They ought to be disciplined and their victims ought to be compensated for their injuries. But there is a compelling need to bring order, reason, and common sense into the situation. Not every retarded child was the product of an incompetent obstetrician; not every injury could be the fault of the other fellow; and not every untoward incident should be an occasion for lawyers to battle it out in courts. Even the best among us cannot be perfect everytime.

The defenders of the current tort system love to spout the line that every American has the right to seek redress in court for a wrong or an injury and that any attempt to limit that access to court is an abridgement of that freedom. That argument, while valid in earlier times, has lost its meaning in the context of the abuses that have overwhelmed the system. The freedom to have access to the courts does not mean that we have to be adversaries for every little incident that ruffles the pleasures of daily living, that we have to perpetuate a system where the only winners are lawyers, and that we have to give up dispensing vital services to the public because the cost of liability protection has gone out of sight. Americans will not tolerate that, and the public interest is far more paramount that should supercede any supercilious attempt by a few individuals with vested interests to continue with the present system.

As the legislators gather once more in session, it is important for them to ponder that liability reform is an issue that they cannot run away from. Forthcoming bills that will address the problem must include important provisions that will put a cap on damages for non-economic losses, abolish the doctrine of joint and several liability, limit contingency fees for

lawyers, and encourage more arbitration. It should be a historic opportunity for our lawmakers to prove that they can rise above partisanship and other differences and finally come up with a solution to a long-festering problem.

R. G. Lacsamana, M.D.
Editor

Turning the CME corner

"The education of a doctor which goes on after he has his degree is, after all, the most important part of his education."
— John Shaw Billings, M.D.

A Union Army Surgeon, John Shaw Billings, M.D., recognized the critical importance of continued learning throughout the professional life of the physician. Following the Civil War, Dr. Billings was placed in charge of the Surgeon General's Library in Washington, D.C., and put his words into practice by increasing the number of volumes from 600 to over 50,000 in a span of eight years. Beginning in 1879, in collaboration with Dr. Robert Fletcher, he published the *Index Medicus* which was a welcomed guide to current medical literature.

Physicians have since come to view medical education as a continuum from medical school to graduate medical education to continuing medical education. These three phases of medical education are organized and treated as separate, distinct segments although, in reality, an argument can be made that continuing medical education actually begins on the second day of medical school.

An obvious distinction, however, is the difference in educational milieu between medical school, graduate medical education and continuing medical education. Among fashionable educational jargon, one hears the terms "pedagogy" and less frequently "andragogy." The former is typically applied to educational processes familiar to anyone who has ever attended school. The emphasis is on rote learning, written examinations, grading, and prescribed curricula. The latter is synonymous with adult learning concepts where the emphasis is on freedom and self-direction. Therefore, continuing medical education is clearly based on the andragogical model.

The freedom to self-diagnose learning needs and choose the most desirable educational prescription has apparently been a favorable condition of learning for the practicing physician. Given this freedom, however, studies have shown that learning styles developed from exposure to years of pedagogy have carried over into the andragogical realm of continuing medical education. Among the most preferred choices of continuing medical education activities remain journal reading and attendance at traditional lectures. Although the fund of medical knowledge is increasing exponentially, the methods of learning have remained relatively constant.

Technology has been embraced in the physician's front office but its use in individualized learning activities has been less than spectacular. Computers have opened up new spheres of opportunity for continuing medical education offering lower costs and greater flexibility. As the PAC MAN generation graduates from medical school and becomes involved in continuing medical education, the use of educational technology will increase. But even though physicians can be certain that technological advances in educational methods will continue and will produce marked changes in their approach to learning, many traditional modes will remain.

Those educational planners who have jumped wholeheartedly on the technology bandwagon will undoubtedly discover that the desire for more conventional educational activities will remain strong. Teleconferencing, satellite networks, computers, and video discs are becoming more and more a valuable part of the continuing medical education repertoire. But the need and desire for interaction with another skillful, caring physician who can present his topic or case study through a live, in-person lecture, discussion, or demonstration will always be central to educational and professional development. Physicians are welcoming and adjusting to educational technology while remaining committed to the essence of continuing medical education which involves the special physician-to-physician relationship from which all patients benefit.

Robert C. Fore, Ed.D.
Executive Editor

DON'T GET OUT OF PRACTICE.



Join Shari Medical PRACTICE MADE PERFECT.

All through medical school you wanted your own practice. Now you have it, but you can't help but notice your phone doesn't ring as often as you'd hoped. With the introduction of HMO's and PPO's it's becoming increasingly difficult to maintain a successful private practice. However, you've worked hard, and you don't want to give up your independence.

Keep your independence but receive the benefits of a group practice

At Shari Medical Center, we believe in physicians helping physicians to increase business. Therefore, every Shari Medical Center is staffed with at least fifteen Primary Care doctors to care for the volume of patients needing general treatment. They will refer exclusively to the Shari specialists-only one physician for each of fifteen specialties.

Plans are for twenty Shari Medical Centers throughout Florida. The locations for each one of these centers has been researched carefully to determine the area with the greatest patient need, and each center will have carefully chosen physicians to fill that need.

Once each physician is invited to join, we'll do everything possible to make sure the practice succeeds. For you as a Shari physician that means state-of-the-art equipment as well as the finest administrative, management, and marketing services that a physician in a small practice couldn't possibly afford.

Most importantly, as a Shari physician, you maintain your independence, so your practice is still your own. You'll receive an equity position in the center and compensation for the services you provide, but you'll have the advantage of exclusive referrals from 30 physicians who are determined to see your practice succeed. Because, when you succeed, everyone succeeds.

Call Shari Medical at (305) 726-6000, outside Broward County, Florida call 1-800-SHARI MD (742-7463)

To find out more about Shari Medical Center, call us. Or, write to us at the address below. We'll be glad to send you a brochure and give you more information on how it is possible to start and maintain a successful practice—made perfect by Shari Medical Center.

SHARI MEDICAL CENTER

Shari Medical Centers, Corporate Offices, 7310 West McNab Road, Suite 103, Tamarac, Florida 33319

©1986 – Shari Medical Center

Polk County Medical Association
SPRING SEMINAR

Grenelefe Resort — (Haines City) Florida

Convenient to both the Orlando (closer) and Tampa (approximately one hour) airports. Grenelefe is centered in Florida's "Vacation Wonderland." Within 30-45 minutes driving time to Walt Disney World's Epcot Center and Magic Kingdom, Cypress Gardens, Sea World and Circus World. If you're driving take I-4 to U.S. 27, south 12 miles to SR 546 East.

Friday, Saturday and Sunday
May 16, 17 and 18, 1986

This seminar has been designed for physicians, office staff, hospital nursing and administrative staffs as well as technicians, medical students, interns and residents. There is no registration fee for allied health personnel but registration is imperative.

Continuing Medical Eduation: AMA Category I — 11 hours; this program has been reviewed and is acceptable for 10½ Prescribed hours by the American Academy of Family Physicians; nursing credit applied for.

— PROGRAM —

Friday, May 16

Stanley C. White, MD, Senior Scientist, Biomedical and Environmental Laboratories, Kennedy Space Center, Satellite Beach, FL

Saturday, May 17

Disciplining the Impaired Physician

Joseph Lawrence, Esquire, Chief Attorney and Director, Division of Regulation, Department of Professional Regulation, Tallahassee, FL

J. Darrell Shea, MD, Chairman, Florida Board of Medical Examiners, Orlando, FL

Donald Weidner, Esquire, Associate General Counsel, Florida Medical Association, Jacksonville, FL

Roger A. Goetz, MD, Medical Director, Florida Medical Foundation Impaired Physicians Program, Jacksonville, FL

Risk Management

Patrice Taverniere, Senior Health Care Risk Management Representative, St. Paul Insurance; Chairman, Health Care Risk Management Advisory Committee for Department of Insurance, State of Florida, Orlando, FL

Leilani Kicklighter, Risk Management, Miami General Hospital, President, Florida Society for Hospital Risk Management, Miami, FL

Robert C. McCurdy, Esquire, Staff Attorney and House Counsel, Lee Memorial Hospital, Fort Myers, FL

John C. Kruse, MD, Anesthesiology, Jacksonville, FL

Sunday, May 18

James Sammons, MD, AMA Executive Vice-President

Neurology of Golden Years

Melvin Greer, MD, Chairman, Department of Neurology, University of Florida, Gainesville, FL

Peritz Scheinberg, MD, Chairman, Department of Neurology, University of Miami, FL

Daniel Traviesa, MD, Neurologist, Watson Clinic, Lakeland, FL

Co-sponsored by the Florida Hospital Association, Lakeland Regional Medical Center, Winter Haven Hospital, Lake Wales Hospital, Bartow Memorial Hospital and Heart of Florida Hospital.

REGISTRATION FEE

Physicians: $185.00

Allied Health: $85.00
(no registration fee — meals only)

Please make check payable to PCMA and mail to: Polk County Medical Association, P.O. Box 927, Lakeland, FL 33802, (813) 682-0543.

POLK COUNTY MEDICAL ASSOCIATION SPRING SEMINAR
May 16 - 18, 1986

GRENELEFE RESORT
SR 546 East, Grenelefe, Florida 33844-9732
(813) 422-7511

No. in Party _____

No. Rooms Required _____

Rate: One Bedroom Villa $105.00
Hotel $ 85.00

- *If more than one person is to occupy a single room, please enclose names and addresses of all persons to occupy all rooms.*
- *Rates are based upon Single or Double Occupancy — additional person charge is $10.00. Children under 18 are free when sharing room with parents.*
- *If room requested is not available, reservation will be made at the nearest available rate.*
- *Special room requests will be honored whenever possible.*
- *The above rates will be honored two days prior and two days after your meeting upon request — subject to availability.*
- *Room rates are subject to 5% state tax.*

In order to guarantee your reservation, please enclose a one-night's deposit, including tax. Reservations received without a deposit will not be confirmed.

Name(s) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Arrival _____ Check In Time is 3:00 p.m.

Business Phone _____ Departure _____ Check Out Time is 11:00 a.m.

Arrival By ☐ Car ☐ Air *(Deposit Refundable If Cancellation Received 7 Days Prior to Arrival Date)*

THE HEALTH CARE WITNESS

What you always wanted to know and couldn't ask.

May 2 and 3, 1986
MARRIOTT'S
ORLANDO WORLD CENTER
Orlando, Florida



This conference is designed to assist physicians and other health care professionals to understand and participate as witnesses in the legal system.

The structure and function of the legal system, role of the witness in relation to the plaintiff's attorney, defense attorney, judge, and jury will be discussed.

Experts from the medical, legal, insurance, court, and academic settings will serve as faculty.

FEATURED SPEAKERS:
Melvin Belli, Esquire
Edward Annis, M.D.

Course Fee: $250 for Physicians
$150 for Other Health Care Professionals

For More Information Call: 305-237-6191

Or Write To: Joanne Weisner
Humana Hospital-Lucerne
818 South Main Lane
Orlando, Florida 32801

Sponsored by
Lucerne Spinal Injury Center
Humana Hospital - Lucerne



DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

The appearance of these tablets is a registered trademark of Wyeth Laboratories

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown, but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia, some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levartereno Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV) **for Anxiety** (lorazepam)

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

Wyeth Laboratories
Philadelphia, PA 19101

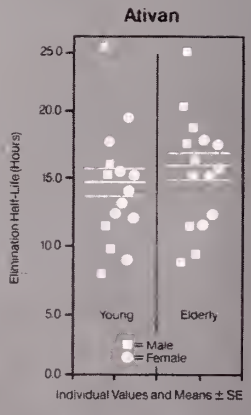
In addition to effective relief of anxiety associated with depressive symptoms...

Only Ativan® (lorazepam) CIV

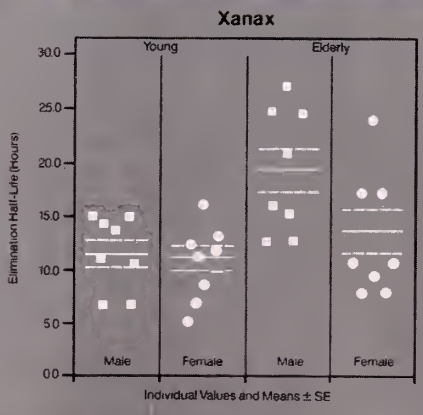
among leading benzodiazepines, has proof that its pharmacokinetics are not significantly altered by age.[1]

With Ativan, elimination half-life was very similar between young and elderly groups tested; differences did not approach statistical significance.[1]

Comparison of elimination half-lives in young and elderly subjects.



Ativan® (lorazepam)[2]
Ativan®, which is *conjugated* rather than oxidized, shows little difference in half-life (t ½) between young and elderly subjects.



Xanax® (alprazolam)[3] CIV
Xanax® requires *oxidative* (P450) metabolism; significant differences in half-life are shown between young and elderly male subjects; half-life is minimally influenced by age in women.

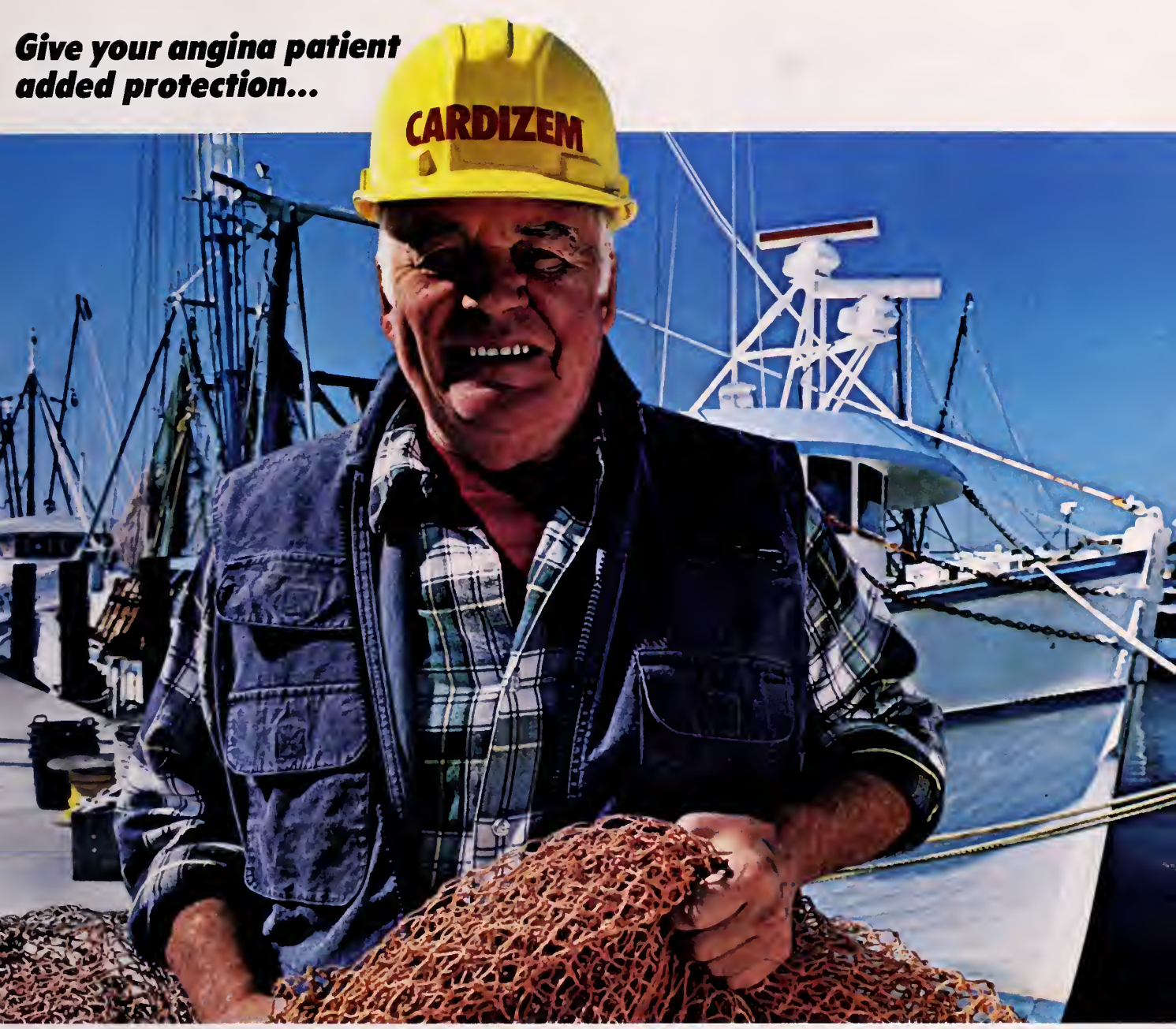
References:
1. Greenblatt DJ: Clinical study, pharmacokinetics and bioavailability in the elderly, Ativan® (lorazepam). Data on file, Wyeth Laboratories.
2. Greenblatt DJ, Allen MD, Locniskar A, et al: Lorazepam kinetics in the elderly. Clin Pharmacol Ther 26:103, 1979.
3. Greenblatt DJ, Divoll M, Abernethy DR, et al: Alprazolam kinetics in the elderly. Arch Gen Psychiatry 40:287, 1983.

Wyeth Laboratories
Philadelphia, PA 19101

See important information on preceding page.

© 1985, Wyeth Laboratories

Give your angina patient added protection...



CARDIZEM®: FEWER SIDE EFFECTS

diltiazem HCl/Marion

- ***The lowest incidence of side effects among the calcium channel blockers[1]***
- ***An exceptionally safe choice for angina patients with coexisting hypertension, diabetes, asthma, or COPD[1-3]***
- ***Proven efficacy when used alone in angina[1, 4-6]***
- ***Compatible with both beta-blockers and nitrates[7]***

Please see brief summary of prescribing information on the next page.



CARDIZEM® 60 mg tid or qid

diltiazem HCl/Marion

FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm**. CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina)**. CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction**. CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension**. Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope
Nervous System	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia
Gastrointestinal	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic	Pruritus, petechiae, urticaria, photosensitivity.
Other	Polyuria, nocturia

The following additional experiences have been noted.

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme, leukopenia, and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LO_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LO_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LO_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers**. (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NOC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NOC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NOC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

See complete Professional Use Information before prescribing.

0642T5

References: 1. *Physicians' Desk Reference®* ed 39. Oradell, NJ, Medical Economics Company Inc, 1985. **2.** Cohn PF, Braunwald E. Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease. A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **3.** Schroeder JS. Calcium and beta blockers in ischemic heart disease. When to use which. *Mod Med* 1982; 50(Sept):94-116. **4.** Subramanian VB. Comparative evaluation of four calcium antagonists and propranolol with placebo in patients with chronic stable angina. *Cardiovasc Rev Rep* 1984; 5:91-104. **5.** Schroeder JS, Feldman RL, Giles TO, et al. Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 1982; 72:227-231. **6.** Weiner DA, McCabe CH, Cutler SS, et al. The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. *Clin Cardiol* 1985; 7:648-653. **7.** Shapiro W. Calcium channel blockers. Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec):150-159.

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137

Let's cure the insanity of "malpractice"

"Drastic illnesses require drastic remedies or none at all. . ."
— William Shakespeare

The medical malpractice crisis began in the early 1970's and it has gradually and relentlessly gotten worse. The state of Florida has the distinction of being one of the two worst states in the nation, along with New York, as far as the number of medical lawsuits and total awards paid. One out of every 3.5 physicians is sued in Florida every year. The national average is 1 out 12

The unabated, nearly geometric, continuous rise in liability premiums which many specialists and surgeons are demanded to pay each year has now reached the 25% to 30% mark of their total practice income each year. It is rather common now to see a surgeon paying $30,000.00 to $70,000.00 in liability premiums in 1986. Each one of these physicians has also had his Medicare reimbursement frozen at the fee rates charged back in May of 1984. Unable to match increases in overhead expenses due to Medicare ceilings, they are forced to attempt to compensate by raising non-Medicare charges. This pass-on fee has only provided a 20% relief if that. Because of this it is probably fair to say that the remaining 80% of their paid liability premiums have to come directly out of their annual incomes.

The malpractice lawyers have entered the medical arena at the dawn of the 1970's. Their mission of trying to "humanize" medicine or to deter the "gougers" (as Ralph Nader calls the doctors) has failed miserably. Was this what they really wanted to achieve? The trial lawyers are continually and openly saying, "there is no malpractice crisis." "You cannot complain about malpractice premiums when it costs you only 4% or 5% of your income" (for some doctors it is now 20% to 30%). "Costs are high because expert witnesses get $5,000.00 to testify." "Don't take it personally, the malpractice premiums are just part of the cost of doing business so simply add it to your fees."

The legislators are not listening to the doctors' complaints. Insurance Commissioner Bill Gunter was always opposed to Amendment Nine and his stand has been generally unfavorable to the doctors' cause. The latest from Mr. Gunter is to blame the insurance companies for the malpractice mess. Is it a coincidence that this is also the latest string being pulled by the trial lawyers?

Michigan doctors marched to Lansing and got very little if anything. The Illinois doctors demonstrated at the capital in Springfield; they were promised drastic concessions by Governor Thompson at the time but they lost everything once the governor's promises went through the legislature. The meek Florida doctors have but a short precious time to turn into mad, fighting lions like they did in Massachusetts before the coyotes devour us all.

Before anything can happen, doctors must sit down and decide what we are demanding, what we are willing to accept, and what we as a group are willing to do if things do not get better within a very reasonable and short time. If our requests are ignored beyond 30 to 60 days, then I will strongly entertain the option of closing my office and stop working except for emergencies.

Some of the major reforms which are needed immediately are:

1. Roll back malpractice premiums to the 1984 level.
2. The maximum liability premium to be paid by any doctor should never exceed 10% of his gross yearly income.

3. The maximum individual malpractice liability for an individual doctor to be capped at $300,000.00 per occurrence. This could be recoverable through the civil courts. Damages sought beyond these figures will have to be filed in the criminal courts only.

4. Immediate establishment of a "State Medical Fund." Each person pays up to $25 per year into this fund (i.e., $0.10 to $0.20 per office visit and $15 to $20 per hospital admission per year). This will be the major source of compensation for all medical injuries.

5. The doctors will make a small initial contribution into the State Medical Fund the first year and gradually increase while at the same time proportionally reduce their other liability premium until by the third year all the doctor's premiums will be paid to the State Medical Fund which then would cover the entire liability spectrum.

6. Those trial lawyers who intend to "benefit" by taking part in this system must also pay a premium on a yearly basis.

7. Immediate activation of arbitration committees.

8. Immediate climination of joint and several liability.

9. Elimination of punitive damages.

10. Maximum compensation for non-economic losses such as pain, suffering, loss of spouse's services, emotional anguish, loss of consortium, etc., capped at $50,000.00.

11. A minimum fine of $1,000.00 to any and every counsel who files a lawsuit which later proves to be "frivolous" or "non-meritorious." This fine should be raised if the lawyer also behaved in a manner consistent with "abuse of legal powers" or if he misrepresented or misstated the facts of the case (notably wildly overstating monetary damages).

12. Abolish the contingency fee system. This Mafia-style blackmail has been abandoned by civilized countries including our alma mater, England. The smell of dollars attracted many lawyers, including famous ones, to help the Bhopal Indians, but all their humanitarian sentiments evaporated in a heart beat after they found out: "Sorry fellows, we have no contingency fees here in India."

13. Reduce the statue of limitations: 2 years from occurrence, may add one year of delayed discovery, but never over 3 years total; in children, maximum of 5 years.

14. Resolution of a case must be decided within one year after filing suit.

15. Once stabilized the State Medical Fund would have the following monetary resources:

1. Hospitals-yearly premium on a sliding scale:
 100 beds @ $200.00/bed $20,000.00
 200 beds @ $190.00/bed $38,000.00
 300 beds @ $180.00/bed $54,000.00
 400 beds @ $170.00/bed $68,000.00
 500 beds @ $160.00/bed $80,000.00
 600 beds @ $150.00/bed $90,000.00
 700 beds @ $140.00/bed $98,000.00
 800 beds @ $130.00/bed $104,000.00
2. Patients — $10.00 per admission.
3. Doctors — 3% of gross or 4% of salary.
4. "Malpractice" Lawyers — 3% of gross or 4% of salary.
5. Nurses, techs — 0.5% of salary.

Self-abrogation of legal power when allowed to grow unchecked by society only gets worse. This cancer in America has grown and metastasized in the last 15 years to the point where it is ready to paralyze, cripple, and perhaps even destroy the nation. Disaster is barely avoidable at this time though it may summon a herculean effort. Should we fail, then we can only reflect and pay homage to the Communist Karl Marx who a few generations ago said: "Let the imperialist Americans fight for money and power; their own greed will destroy them from inside." The onus is on us all to prove him wrong. . . .yet.

Robert Benedetti, M.D.
Clearwater

Editor's comments: Dr. Bendetti and other physicians will be pleased to know that the Reagan administration has acknowledged that there is indeed a crisis in liability insurance and has joined the bandwagon to come up with long-overdue reforms in the tort system. The assembly in Tallahassee by members of the Florida Coalition for Liability Reform on April 21 will highlight the united stand of various sectors of the public, including the medical profession, for necessary changes in the current legal system. Making reforms will not be easy but physicians are no longer alone in this fight.

Bravo!

I have just finished reading your editorial "Quality of Care in Jeopardy" in the February issue of *The Journal of the Florida Medical Association.* Your summation of the problems we face in medicine is succinct and to the point and it is my hope that many of us who receive *The Journal* will take the time to read this editorial. I concur with your findings and recommendations wholeheartedly. Keep up the good fight.

John M. Harper, M.D.
Ft. Lauderdale

AMA: best medical "union"

Having read the comments of Thomas Scott, M.D., regarding the need for medical unionism, I would suggest that the American Medical Association is, if properly supported, our most effective national "union." Dr. Windom in the same issue of *The Journal* made the point that we should be more aggressive in our efforts to promote membership in the AMA. I would suggest that the time has come for the Florida Medical Association to become a unified society and require AMA membership as a condition for membership in local and state societies.

Karl M. Altenburger, M.D.
Ocala

Editor's comments: *The Journal of the Florida Medical Association* has no axe to grind against medical unions and has tried as best as possible to present both sides of the issue in a fair way. *FMA Today*, a sister publication of *The Journal*, gave comprehensive coverage in a recent issue on the symposium on medical unions held in Tampa during the Leadership Conference, including the arguments propounded by Dr. Marcus. Because of the intense interest generated by medical unions, including several letters to the editor, *The Journal* is pleased to print in the Medical Economics section an argument from Arthur Hall, M.D., an articulate spokesman for medical unions. Space limitations do not permit us to publish other letters but *The Journal* wishes to acknowledge the interest of the readers on this subject.

Dissent from California

I cannot tell you how disappointed I was at your article, "Should Florida Physicians Embrace Medical Trade Unionism?" in your issue of February 1986.

Considering the fact that I traveled six thousand miles to address your Leadership Conference on the subject, on January 25th, and that I brought with me one of the outstanding legal authorities on the subject of medical unionism, I found your article to be biased, ineffectively presented, and non-responsive to the critical issues that were discussed in depth at your leadership session.

Your allotment of only 12 column-inches to the "pro-union" argument (which was featured by an obvious lack of understanding of any but the most superficial rhetorical issues) while allotting 43½ column-inches to the "anti" argument (most of which was shot through with such an anti-union bias that it constituted ineffectual and non-responsive sputtering when compared with the serious issues addressed at your seminar) seems to indicate where your personal editorial preferences lie.

You might try to erase this forensic disaster by simply publishing a transcript of the talks given at your own Leadership Conference — even including all the anti-union remarks. By so doing you will reestablish your own reputation for veracity and objectivity, while giving those physicians not privileged to attend a real view of the debate on medical unionism.

Sanford A. Marcus, M.D.
President, Union of American Physicians and Dentists
Oakland, California

Defending Quality of Care

Your editorial in the February 1986 issue of *The Journal of the FMA* (Quality of Care in Jeopardy) was excellent. It is the first time that I have ever seen the word militancy used by any representative of the Florida Medical Association.

Vigilance is fine but we cannot continue to apathetically sit back and watch as the walls crumble and our enemies continue to pour over without our engaging in some form of militancy.

As the quality of medical care gradually deteriorates, the public and politicians will some day again reinvent the wheel and realize that private practice was what made medical care in the United States the greatest in the world and probably, some day, consider returning to it. As the quality deteriorates through HMOs and PPOs, as we know it will, the public and the media will probably blame doctors again. A public relations campaign is extremely important to counter the barrage of deceitful advertising by HMOs. The public must be told the truth and we must fight back vis-a-vis the media and paid advertising as best as we can. We must also consider legal actions against HMOs and PPOs, if nothing else, to enlighten the public as to the way these organizations truly function for the sake of money, not quality, via the process of discovery. We must find causes for which to file legal action or actions and hire attorneys who are willing to plow new paths in the laws to protect us as equally as the law protects HMOs and PPOs.

We have devised the greatest health care system the world has ever seen and now, for the sake of financial reward for the business community, they are willing to allow this great health care delivery system to be slowly dismantled for money and with total disregard for quality. The obscenity alone of the presi-

dent of Humana Corporation earning over eighteen million dollars in salary last year is evidence enough for our cause.

I was also a little disturbed to see what I thought was obvious prejudice against unions in the Medical Economics section. Although Thomas Scott Jr., M.D., did an excellent job in his article, he is not a known union leader in this country or in this state and the task of defending unionism should have been given to either Sanford Marcus, M.D., or to the President of the Florida Union, Osvaldo Contarini, M.D., in Jacksonville, Florida.

When somebody else comes up with a better concept as to how to fight back and preserve and protect the medicine that we have and that we know, then I will be more than happy to listen to his opinions. Jacques Caldwell, M.D., editor of the *JFMA* Medical Economics Section, does nothing more than give an encyclopedic review of unionism and a response to Dr. Scott's article without coming up with a better idea as to how to skin the cat.

I no longer care how far down on the rung of opinion poll ladders unions stand, because no matter what we do, we are still going to be criticized and socialized. We are fighting an unequal battle in that we have ethics and morality but our enemies do not. Damn the opinion polls because they are not what is going to save medicine. It will only be saved by our actions and not the inactions desired by the minority on the basis of our public prestige, which is a totally unknown entity. Our public prestige has nothing to do with it. The plain and simple facts are that industry wants us socialized and wants to take over medicine for its own economic gains and industry is what is being quoted in the media as being the public.

We have always been an honored and esteemed profession. We have been moral and ethical. We have been concerned about the public and the public welfare and have always been high on the ladder of public opinion. If all that is true, then where is the public defense of our profession and why have I not heard one word from the "public" in our defense? The public is whoever the politicians and the media desire them to be and in the case of our socialization, the public is industry. Last year, before the annual meeting of The Medical Foundation of South Florida, the guest speaker was a representative of the Fortune 500 Club whose name I cannot recall. He told us, very bluntly, that unless medicine does what the major industries want them to do, then the industries are going to take over and control medicine and there is no two ways about it. He warned us of what was going to happen. He told us how it was going to happen. He told us who was going to do it to us. Yet, we sit back nonchalantly and write that "The public's attitude towards physicians is like religious faith — faith in physicians' integrity, concern for the public health, and the physicians' compassion and altruism." Again, I ask you, if this be true, then where is the public in our defense?

Unfortunately, we probably will continue to discuss our problems into oblivion without ever taking appropriate counteractions and without ever getting mad enough to finally fight back. Militancy is the key word and it is about time we called it what it is because it is the only hope we have left and the only salvation medicine has in its future.

Richard L. Glatzer, M.D., P.A.
Miami

Rejoinder from pharmacy dean

I noted in Dr. Joseph Webster's letter in the February 1986 issue that he stated "at the hearings before Representative Kelly" on the recent legislation allowing pharmacists to prescribe certain drugs, he "witnessed members of the faculty of the pharmacy school argue quite forcefully for this provision."

That is not an accurate account. Members of the faculty of the College of Pharmacy were requested by legislators to appear before committees to provide information on the education of pharmacists. They did just that.

Dr. Webster also states that "the real movers toward changing the role of pharmacists are located at the School of Pharmacy at the University of Florida." We are very proud of the advances we have made in the education of pharmacists to enhance their ability to participate in health care of the public. We make our advances through education and research in concert with education of physicians and other members of the health care team and leave legislation and public policy activity to others.

Michael A. Schwartz, Ph.D.
Dean
College of Pharmacy
University of Florida
Gainesville

University of Miami
School of Medicine
Department of Medicine

REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE

May 12-16, 1986

Key Biscayne Hotel & Villas
Key Biscayne, Florida

A course especially designed for physicians who are preparing for board certification or recertification in Internal Medicine.

State of the Art Lectures

—

Meet the Faculty Sessions

—

Patient Management Problem Sessions

—

Audiovisual Aids

—

Self-assessment Questionnaire Sessions

—

Pictorial Quizzes • Printed Materials

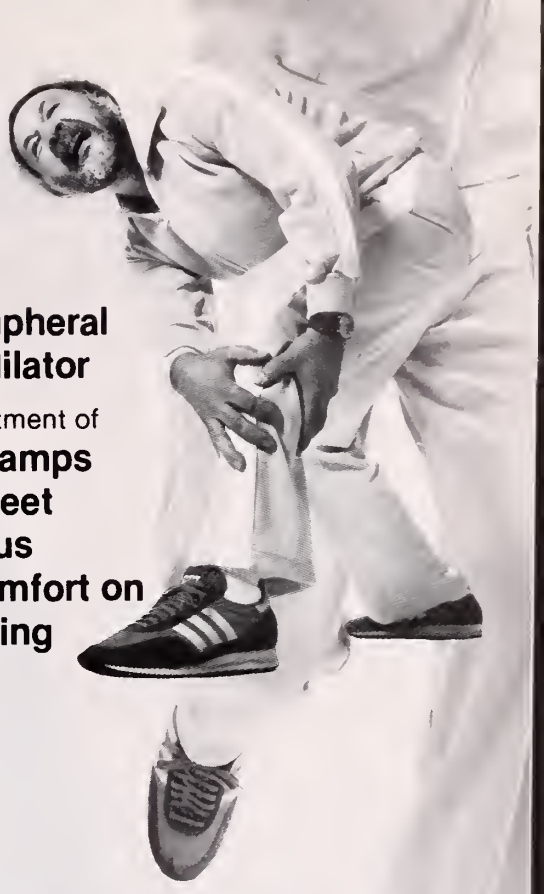
—

39.5 Hours of AMA Category I Credit

Registration: $325 (before March 30, 1986)
$350 (after March 30, 1986)

For registration and information write to:

J. Bocles, M.D., Department of Medicine (R760), University of Miami School of Medicine, P.O. Box 016760, Miami, Florida 33101. Phone: (305) 547-6063.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.
Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

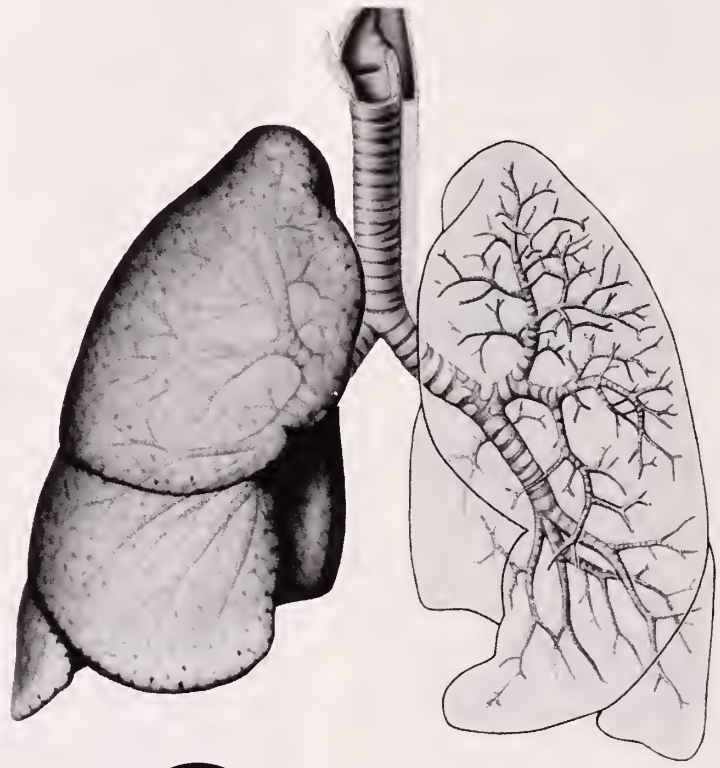
Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SCPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

© 1984, ELI LILLY AND COMPANY

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

400441

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
APRIL 1986, Vol. 73, No. 4

Guest comments — JFMA historical issue



Organized public health in our state has a history spanning over 100 years that is to be cherished. Typhoid, yellow fever, and malaria have been eradicated as significant diseases within our state. Other diseases like measles and polio require continued vigilance pertaining to immunization practices. County health departments exist in our sixty-seven counties and are the essential backbone of Florida's official public health delivery system.

However, history has more significance than this to be cherished. What can we learn from it? What lessons can be gleaned from history for today, tomorrow, toward the year 2000?

First, public health is and will always be an essential element of societal structure. Public health's facies and challenges may change but its need by civilization will not. We do not have yellow fever in Florida today, we have AIDS. Indigent health care challenges are as great as ever. Drug abuse and health needs of the elderly are but two of our great modern day challenges. We know more than ever before pertaining to what causes death and disability but many causes encompass lifestyle behavior, i.e., alcohol consumption, cigarette smoking, violence by guns. Health education is as vital as ever. Chemical contamination of water and food joins biological contamination in the need for public health investigations and safeguards. Tuberculosis continues to ravage too many of our poor and alcoholic. Epidemiology investigations are as necessary and as complex as ever.

We should take pride in our accomplishments and armed with knowledge, ethics, vigor and humility address the challenges of today and tomorrow. Who are "public healthers?" HRS employees? University scholars? Private practicing physicians? Nurses? Sanitarians, to mention a few? Just like the last 100 years, we all are! We all dedicated ourselves to the betterment of mankind. We all need each other's knowledge and wisdom to insure that our society has the best public health possible. The public health family is large; we all need to be active members for the health and well-being of Florida's citizens and visitors. I cannot predict much but I will predict that in our megastate, public health will be most exciting and challenging to the year 2000. Choose one or a few public health problems to work on; there is plenty to go around!

James T. Howell, M.D., M.P.H.
Staff Director, Health Program Office and State Health Officer, Department of Health and Rehabilitative Services

Our debt to public health

This issue of *The Journal of the Florida Medical Association, Inc.*, is devoted largely to the history of public health activities in Florida. By necessity, *The Journal* has only space for a brief foray into the fascinating and often neglected story of public health in this state. Of all the specialties in medicine, public health seems to be the least publicized and yet has probably been the most influential in terms of its overall impact. The story of public health is, of course, not confined to the state of Florida. It has been present for hundreds of years and in the opinions of many, laid the basis for modern medicine and is the cornerstone of our medical system. Long before the invention of antibiotics, CAT scans, organ transplants and other technology, public health measures were saving thousands of lives and preventing sickness by careful observation and changing the environment in which we live by mosquito control, privy construction, diet instructions and many other measures. In the nineteenth century public health held a much higher position of prestige than in today's medical community. The predominant reason was that there was no other specialty which could offer as much. The list of accomplishments is impressive. Scurvy, the enemy of the British Navy, was conquered after a physician made careful observation that the cause was lack of a vitamin, which could be supplied with fresh citrus juice. The transmission of yellow fever was found to be through mosquitos after an American doctor had pieced this puzzle together and even though a cure for the virus was not yet found, its incidence was greatly reduced by draining the swampy breeding grounds of the *anopheles* mosquito. The list goes on and on. However, over the past 50 years it appears that public health has been relegated to a position of lesser importance. This is a result of several things. The most important is that technology has superseded almost all else in medicine. It is much more fashionable to be interested in the latest artificial heart transplant or the newest advances in radiologic imaging than to become enthralled in venereal disease control, tuberculosis, or prenatal care for women.

Because of the rush to be involved in scientific advances, we are in very real danger of forgetting those pioneers of early medicine and the work that was accomplished by them. Many physicians who are practicing today are not aware of the tuberculosis hospitals which were established in Florida and treated thousands of patients. The public health sector furnished many physicians who exposed themselves to infectious disease and great dangers in treating victims of yellow fever epidemics which periodically swept Florida. Public health doctors went among the polio victims and traveled throughout the state educating the people about the cause and prevention of hookworm disease. Sadly, many of these men and women have been forgotten, except in dusty reports and a few textbooks. Yet, without the benefit of high technology, public health was responsible for some of the most memorable events of medical care in this state. The story of the establishment of the state Board of Public Health and county health departments is a fascinating story of the persuasion, political maneuvering and organization ability of some of these men and women.

What was accomplished during the early part of the twentieth century is still being carried on today, but like its earlier action, public health and its accomplishments are not widely known. Public health has managed to continue to improve the lives of the citizens of this state and appears to be the safety net that treats and affects thousands of people who may not otherwise receive medical care. The prenatal care clinics are responsible for preventing many birth com-

plications and potentially millions of dollars in medical care. Venereal diseases clinics operate across the state and without incrimination or moral judgement treat and attempt to educate those with the diseases. Immunizations given by the county health departments have helped to reduce pediatric mortality and morbidity. Suffice to say, the medical profession and the general public owe a great deal to the public health sector of this country. Our heritage has enriched us in the achievements of public health and those achievements are still going on today.

It is hoped that this issue of *The Journal* will provide a brief journey into the past and serve to remind us of the pioneers and accomplishments of early public health in this state. There are hundreds of stories to be told and unfortunately there is not enough time left for all of them to be revealed. Many of the pioneers and early workers have passed away and others are in retirement. The state and county public health departments kept adequate records, but while the records can give the bare fact and figures it sometimes takes a participant to bring out the "flavor" or to translate facts into feelings and emotions. Many of the contributors of the articles in this edition of *The Journal* were present during some of the historical events which affected public health in this state. If they were not actual participants, they are very familiar with the events which transpired. All of the contributors have penned fascinating stories which help to contribute to our knowledge of the history of public health activities in Florida.

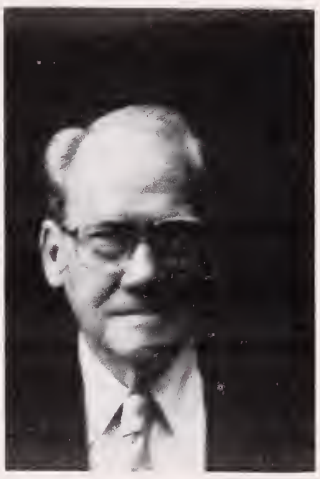
In addition to public health activities, there is an article on typhoid fever in Florida in the late nineteenth century, written by William Straight, M.D., the former historical editor of *The Journal.* As always, Dr. Straight has written a lucid historical account of the misery and devastation of a disease out of control. Besides its value as a historical account of typhoid epidemic, it also serves to reminds us of the ravages of a disease that is, at least, partially controlled by sanitary measures. Even though the public health department did not participate in the epidemic, public health measures obviously came into play in an attempt to stop the disease.

Thanks from all the physicians of this state are due to the contributors of this issue of *The Journal.* They have taken their time and through tireless efforts have enriched all of us with their stories of bygone days and forgotten events.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor
New Smyrna Beach

A local public health experience — history of the Palm Beach County Health Department

C. L. Brumback, M.D.



In development of its public health program, Florida has been blessed by the close relationship between public health officials and the Florida Medical Association. Indeed the persistence of the Association in urging establishment of a State Board of Health was a primary factor in the ultimate success of this effort. Physicians such as John P. Wall, M.D., of Tampa, a past president of FMA, were in the forefront of this movement in the late 19th century. Dr. Wall's testimony before the state legislature included this classic statement: "The duty of preserving the health and lives of its citizens from the cause of disease is as incumbent on the state as is that of suppressing rapine and murder."

When the Florida State Board of Health was eventually established by act of the legislature in 1889, one of the state's most distinguished physicians, Joseph Y. Porter, M.D., was selected as the first State Health Officer. This also was most fortunate. Dr. Porter was not only an excellent physician; he also had considerable experience in public health and he was highly regarded by both his colleagues and the public. A basic precept he established, which has continued to the present time, is the close working relationship between organized medicine and public health. He realized that the goals of public health cannot be achieved without this relationship.

The concept of close cooperation between the official public health agency and organized medicine established at state level has generally been followed at the local level. Since establishment of the first county health unit in Taylor County in 1930, county medical societies have been involved in varying degrees with formation of a succession of local health units in the other counties of the state. Because of the great variation in local circumstances, one would scarcely expect a uniform situation throughout Florida. There have been great differences in problems, resources, personalities, local politics and other factors which have a great deal to do with development of any public health program. In spite of some negative factors in these relationships, a prevailing element of cooperation has enabled Florida to develop one of the best public health programs in the nation.

Words of wisdom from Wilson Sowder, M.D., who served as State Health Officer from 1945 to 1974 express the accepted philosophy during his administration: "It is impossible for a health officer to do good work without proper relationships and understanding with his fellow physicians in private practice. The public interest is better served by strengthening the private practice of medicine and by delegating only those problems to public health which cannot be handled adequately on a retail basis in private practice. Work closely with the public health committee of the county medical society." Advice to members of the Florida Medical Association was: "The voice of the medical society is heard and heeded in the

The Author
C. L. BRUMBACK, M.D.
Dr. Brumback is Director of the Palm Beach County Health Department.

councils of the State Board of Health. A good health department is a credit to the medical profession; a poor one reflects on your public spiritedness. We cannot have a good statewide public health program without your cooperation and assistance. Health departments need constructive criticism and guidance from members of the profession best able to give it."

Public health services • This article describes local efforts to develop public health services in Palm Beach County. Although certainly not typical of the state as a whole, this county includes elements common to counties throughout a major portion of Florida. There are urban and rural areas made up of a cosmopolitan population comprised of a number of ethnic groups with different cultural, educational, age, occupational, economic and other characteristics. The public health problems certainly cover a broad spectrum of disease and related factors.

An abortive attempt was made to establish a health unit in Palm Beach County during the early 1920s. This effort occurred at a time when county health units were being established at an accelerating pace in other states largely as a result of the work of the Rockefeller Sanitary Commission. Unfortunately state funding for public health was drastically reduced at about this same time forcing abandonment of plans to develop local health units. It was not until 1948 that a move to establish a health unit in Palm Beach County was successful. By that time, each of the 67 counties in Florida had a county health unit except six. A major reason for the further delay in establishment of this unit was the fact that the county seat, West Palm Beach, had been successful in establishment of a city health department in the mid-20s and this agency had developed to considerable size. Furthermore, the county welfare department, schools, voluntary agencies and others had picked up various pieces and bits of public health services so some basic needs were being partially met.

In spite of the number of participants in providing segments of public health services, there were many problems and unmet needs. Although it was larger than the Palm Beach County Health Department, the city health department had only a rudimentary program consisting of a small public health laboratory, basic public health nursing, food service inspection, veneral disease and tuberculosis clinics, and some epidemiology. There was a part-time health officer who had other major responsibilities, public health nurses, sanitarians, a bacteriologist and clerical support. The schools employed four nurses who worked countywide. The West Palm Beach Kiwanis Club supported a dental clinic for children in that city, and the county welfare department operated a small clinic primarily for older people. The private physicians cared for many people without compensation, and most indigent patients were seen in emergency rooms of the four private hospitals.

Duplication and conflict • The county health department got off to a slow start. By 1950 the total budget was $92,000 and this supported a staff of 20. In spite of large gaps in services, there was considerable duplication and conflict. The Palm Beach County Medical Society together with the county commission and others wanted a change in the situation. The challenge was there but also the potential for cooperation and accomplishment. The medical society pledged its support and asked only to be involved in the process.

The public health problems were so great that priorities were difficult to set. A very active committee of the medical society met with the newly appointed county public health director and considered the various problems and needs. A survey showed a total of 56 major problems and an attempt was made to prioritize these. Environmental pollution was at the top of the list because at that time there were no municipal sewage collection and treatment facilities in the entire county. In the coastal area, a major portion of the sewage not going into septic tanks went untreated into the intracoastal waterway converting this body, known as Lake Worth, into an open sewer over 30 miles long. Bacteriologic and dissolved oxygen studies were performed by the health department engineer and charts prepared depicting the findings. An educational campaign was launched in cooperation with the county medical society and other community groups who offered their help. A local surgeon developed a technique to project microscopic organisms onto a television screen which was quite effective.

In spite of these efforts, progress toward establishing a sanitary district was stalled by powerful opposition from groups who objected to the increase in property taxes which would be required to build the necessary sewage collection and treatment systems. The medical society then took action, passing a resolution declaring this widespread pollution to be a health menace. The local newspaper cooperated by giving appropriate coverage. A public referendum to establish the needed sanitary district was successful largely because of this medical support.

Recognizing the lack of organization in provision of public health services, the county medical society initiated a program of cooperative action. First, agreement was reached between the School Board and the Board of County Commissioners for school nurses to be transferred to the county health department. The Palm Beach County Dental Society subsequently took corresponding action with the West Palm Beach Kiwanis Club in placing the dental program also under

health department administration. In 1953, the Executive Committee of the county medical society met with the West Palm Beach City Commission and the Board of County Commissioners of Palm Beach County and was instrumental in achieving an agreement to combine the city and county health departments. These organizational changes eliminated duplication of services, jurisdicational conflicts and resulted in more and better quality of services being delivered with greater cost effectiveness. Another change supported by the medical society was a combination of the West Palm Beach City Health Department's laboratory with the laboratory of the state tuberculosis hospital located in Palm Beach county. This combination when augmented by the state to provide additional personnel resulted in formation of a new state Regional Public Health Laboratory.

The county medical society regularly considered public health problems at meetings of its Executive Committee and continued over the years to play a very active role in participating in the solution of these problems. The county health director and members of his staff regularly attended these meetings as members or ex officio members of the committee.

Migrants and farm workers • One of the early joint projects recognized the health needs of agricultural migrants and seasonal farm workers. In 1950 an estimated 56,000 including family members were in Palm Beach County. A study of these needs was recommended and funding obtained from the U.S. Childrens' Bureau. Two individuals were employed by the county health department, one of whom accompanied a crew of migrants as they when up the Atlantic Coast and back. Through this study, information was obtained which formed the basis for another proposal to devleop a team effort for effectively providing health care to these workers. The proposal called for physicians, (family practitioner and pediatrician), public health nurses, nutritionist, health educator, social worker, sanitarian and a liaison worker from the migrant culture. The proposal was approved for a five year grant from the Children's Bureau and a cooperative program was initiated in 1956. This team approach demonstrated that it was possible to deal with these very complex health problems in an effective manner, adapted to the cultural, educational and work patterns of the target population.

Medically indigent • Largely because of the success of this program, the Board of County Commissioners asked for a study of the county's total method for providing care to the medically indigent. Palm Beach County has no public hospital although there are three hospital taxing districts. The major population area surrounding West Palm Beach is not included in any of these districts. In the 1950s indigent patients made unplanned visits to physicians offices or to emergency rooms of hospitals. The only public clinics were a small one operated in West Palm Beach by the county welfare department and those of the health department. Physicians largely contributed their services with no reimbursement.

The county health department was requested by the Board of County Commissioners to assume general responsibility for overseeing and coordinating health care of the indigent population, an awesome challenge which could not begin to be accomplished without a team effort with the county medical society. Accordingly a series of meetings was held not only with the Executive Committee but also with the entire society and various specialty groups. Gradually, through the 1950s a plan emerged which was developed incrementally. This plan was implemented in the same cooperative manner.

In this county-wide program of health care for indigent patients private physicians provided most of the medical care. This was done in health department clinics, in hospitals, and by referral to private offices. A system of payment was developed for hospitals and phyisicans using a combination of funds from various sources. Such reimbursements were not equivalent to usual and customary fees but they were a considerable improvement over the previous situation. Several health centers were constructed over a period of years which were located in areas accessible to the various needy populations.

In order to provide care of acceptable quality, a highly qualified professional staff was required. Since the target population represented all age groups and a broad range of pathology, various specialists were needed capable of handling the large number of high risk situations encountered. To assist in attracting such staff, training programs were developed which included an approved residency in preventive medicine. Agreements and contracts were also negotiated with specialists in the community who provided their expertise in developing comprehensive services and continuity of care. Agreements with hospitals, emergency rooms and laboratories brought these resources into this county-wide program.

Certain aspects deserve special attention such as a program designed to reduce infant mortality and morbidity. This was developed by a group of pediatricians working with the health department and also involved groups of obstetricians. The result of this cooperative effort was a program which included prenatal care accessible to maternity patients throughout the county, identification of high risk patients, and provision of appropriate care to mother and baby through prenatal, perinatal and postnatal periods. Since initiation of this program, a marked reduction in mortality and morbidity has been seen.

Numerous other examples of cooperative efforts between private and public sectors could be given. The result has been the progressive development of a

system of care through which individuals eligible for Medicaid or certified under standards developed by county human services have access to quality health care. Since emphasis is placed upon primary and preventive care in this system, it has proven to be cost effective as well.

Conclusion • Development of local public health services in Palm Beach County was accomplished through close cooperative efforts of the county medical society, county health department, and support of a number of public and private agencies and groups. These programs have been developed to the point that they include a wide range of personal and environmental services.

In addition to the traditional public health services usually provided by local agencies, medical care problems of underserved populations have been addressed and programs developed to meet the specific needs of these groups. Services provided through these programs have been made accessible to the people in need of them through regional health centers. Agreements and contracts with hospitals, emergency services, laboratories and specialty groups assure comprehensiveness of the services available and continuity of the care provided. Emphasis on primary care and preventive services promote optimum quality and assist in cost containment.

Recruitment and retention of qualified staff have been materially assisted by training programs which include an approved residency in preventive medicine. Quality assurance programs have been implemented so that the care given meets acceptable standards.

The goals and objectives could never have been achieved without the cooperation and support of the Palm Beach County Medical Society which has continued throughout development of this program. This cooperation in planning as well as implementation of health care services is the key element in success of these programs.

References

1. Koos, E.: They Follow the Sun, Florida State Board of Health Monograph No. 1, Jacksonville, Florida, 1957.
2. Browning, R. and Northcutt, T., Jr.,: On the Season, Florida State Board of Health Monograph No. 2, Jacksonville, Florida, 1961.
3. Hardy, A. and Pynchon, M.: Millstones and Milestones, Florida State Board of Health Monograph No. 7, Jacksonville, Florida, 1964.
4. Brumback, C.: Coping with Changing Health Scene: Local Health Department's Experience, J. Pub. Health Policy 3:342, 1982.
5. Brumback, C.: Comprehensive Care in Local Health Department, Florida Pub. Health Assn. J., 1:2, 1984.
6. Cowdery, P.; Rushton, F., and Brumback, C.: Indigent Care — Growing Dilemma in Competitive Health Care Industry, J. Florida M. A., 71:691, 1984.
7. Brumback, C.: Access to Care for Medically Indigent — Palm Beach County Experience, Presented at Access to Care for Medically Indigent, Invitational Conference, San Francisco, California 1984.

• Dr. Brumback, Department of HRS, Palm Beach County Health Department, Box 29, West Palm Beach 33402.

Indigent care and public health in Florida, 1931-1985

E. Russell Jackson Jr., M.A., M.P.H.



The legislature created the Florida Task Force on Competition and Consumer Choices with Chapter 82-182, Laws of Florida, in 1982. The Task Force's report in 1984 included recommendations on health care cost containment.[1] As a result of the law and report, the legislature enacted the Health Care Access Act of 1984, Chapter 84-35, Laws of Florida. The major intent was to contain health care costs through establishment and enhancement of a competitive delivery system in which the health care market would be characterized by alternative provider and financial arrangements in competition for the consuming public as purchaser of services and potential patient. The Act further stipulated that "access to adequate health care is a right which should be available to all citizens."[2]

In view of the dynamics of a changing federal policy toward the degree of federal governmental involvement in the health care field, the State of Florida thus embraced in 1984 a public policy that not only encouraged but actually demanded that competitive economic forces be developed by the private sector in Florida's health care marketplace. Yet, in calling for competition among alternative delivery and insurance mechanisms the Health Care Access Act also sought to make health care services available for indigents below the federal poverty level and who do not qualify for Medicaid. The law also intended that access to health care be provided to the medically indigent with income certified below 150% of the federal poverty level and who do not qualify for Medicaid or who are otherwise uninsured.

The extent of state government involvement in the competitive marketplace envisioned by the Health Care Access Act was undefined in the Act. Moreover, the mechanism by which state government was to assure access to health care for the indigent was not explicit. A major role appears intended for the public health system both as provider and broker of health care services for the state's indigent population which, according to a study undertaken in 1985 by Louis Harris and Associates, was estimated at 4.2 million persons with incomes at or below 150% of the federal poverty standard.[3] An estimated 1.6 million were not covered by public or private health insurance at the time of the study.[4] The purpose herein, therefore, is to identify the mission of public health regarding indigent health care in a competitive environment from the perspective of recent state law and the historical development of public health as a provider and broker of indigent health care services.

The Author
E. RUSSELL JACKSON JR., M.A., M.P.H.
Mr. Jackson is the Assistant Director for Medical Economics of the Florida Medical Association.

The Burnsed Act of 1983 • Chapter 154, Part I, Florida Statutes, is known as the "County Health Unit Enabling Act." It was originally enacted in 1931 creating a cooperative partnership between each

county and the state for the provision of public health services. By 1941 a total of 33 counties had joined with the state's public health department, the State Board of Health, and all but one of the 67 counties had become partners by 1952. In 1960 St. Johns County completed establishment of a coordinated statewide public health system.[5]

Since passage of the County Health Unit Enabling Act there have been significant changes: in medical technology and effectiveness of public health communicable disease control; advances in the professionalism and specialization of public health workers; growth and expansion of large health departments in urban areas; emphasis on chronic disease control; and provision of direct clinical services at 229 county public health unit sites. During this period services were categorized as either environmental or personal health. Preventive services such as immunizations, health education, nutrition, and clinical treatment services for the acutely ill were classified as personal health services.

Then in 1983 the legislature passed a landmark law generally referred to as the Burnsed Act after its principal sponsor, Representative Beverly Burnsed, D-Lakeland, who was chairperson of the Florida House of Representatives Committee on Health and Rehabilitative Services. Her bill, which became Chapter 83-177, Laws of Florida, significantly altered for the first time the County Health Unit Enabling Act of 1931.

Among its many provisions, the Burnsed Act mandated that the Department of Health and Rehabilitative Services, successor to the State Board of Health, enter into formal contracts with each county in order to specify the services to be provided in individual county public health units, anticipated number of persons to be served, and amount of funding necessary for provision of services. The Act also mandated that "All contracts shall be negotiated and approved by the appropriate local governing bodies and the appropriate district administrators. . . .The contract shall stipulate those public health services, personal health services, and primary care services which are to be provided."[6] Table 1 lists the types of services.

Public health services ● Public health services are defined as "those services made available to the healthy public as client and which are organized and operated to protect the health of the general public. . . ."[7] These services are to be funded from available federal, state, and local sources. Costs remaining after taking into account federal monies other than block grants are to be paid by the state contributing 70% of the balance and each county contributing 30% of such balance. Among services categorized in the public health grouping are those previously considered personal health services such as immunizations, sexually transmitted disease control, and tuberculosis control. While these services are available to the general public with no eligibility requirements they are provided to persons who in general would be classified as being among the indigent or medically indigent including Medicaid and non-Medicaid eligible individuals.

Personal health services ● Personal health services are defined as "those services which are made available to the individual well person as client" including individual members of special groups provided in group settings or clinics for the maintenance of health and prevention of noncommunicable disease.[8] The state is to contribute 50% and the county 50% of the balance for the costs of these services after allocation of federal funds other than block grants. In general, persons who receive clinical personal health services must meet low-income eligibility requirements or be program eligible or both as in the case of maternal health, improved pregnancy outcome, and well-baby care. Again, individuals receiving these services primarily are either Medicaid eligible or else classified as medically indigent or the uninsured indigent.

Primary care services ● Primary care services are defined as "those services which are made available to individual injured or ill persons by the provision of medical care in public health units, clinics, or homes. Primary care services shall include those medical services which have been determined locally to be appropriate and feasible and shall be funded through the several sources available, such as federal or private health insurance, client fees, or from state or local government funds if available."[9] In 1984 the Health Care Access Act authorized the Department of Health and Rehabilitative Services to use up to $10 million from the Public Medical Assistance Trust Fund to establish primary care for low-income persons through county public health units.[10] Table 2 shows that 35 county public health units submitted 33 proposals (Washington and Holmes Counties submitted a joint proposal as did Leon and Wakulla Counties) for fiscal year 1985-86. Of the proposals submitted, 17 were approved enabling 18 counties to participate. The total number of participants was limited by the amount of funding. Counties not receiving approval still have their proposals in place; moreover, additional counties are expected to submit proposals when additional funds become available.

The Third Annual Report of the Florida Public Health Unit Subcouncil submitted on July 12, 1985 to the Governor, President of the Senate, Speaker of the House, chairpersons of the Senate and the House HRS Committees, and Secretary of HRS lists the following provisions which a county public health unit primary care proposal should contain:

Table 1. — Statewide Summary of Annual Planned Clients, Services and Expenditures, Contract Year 84-85.

Level of Service/ Service Area	Clients/ Units	Services	Total Expenditures	Percent: State	Percent: County
Public Health					
Immunization	395,210	897,945	$ 5,069,426	74	26
Sexually Trans. Disease	170,723	535,469	6,089,491	74	26
Tuberculosis	200,431	621,376	4,180,920	73	27
Comm. Disease Surveillance	26,679	82,425	2,767,563	74	26
Occupational Health	195	3,157	110,480	75	25
Consumer Product Safety	665	4,258	140,125	78	22
Emergency Medical	1,123	4,606	199,657	63	37
Food Hygiene	58,760	322,222	7,741,293	68	32
Food Hygiene Training	14,791	11,099	329,850	69	31
Group Care Facility	10,742	50,550	1,854,343	76	25
Migrant Labor Camp	235	1,803	176,412	79	21
Housing and Public Building	15,306	42,356	779,896	81	19
Mobile Home and Park	6,067	28,143	1,026,105	69	31
Common Carrier Sanitation	421	2,731	57,341	85	15
Private Water System	12,496	56,162	891,460	67	33
Public Water System	14,172	393,218	3,058,192	72	28
Bottled Water	61	1,846	49,306	79	21
Pools/Bathing Places	23,484	146,196	2,331,287	68	32
Individual Sewage	62,644	257,179	4,873,538	73	27
Public Sewage	2,492	6,409	495,620	89	11
Solid Waste Disposal	1,242	4,150	434,060	54	46
Sanitary Nuisance	49,654	141,818	2,292,985	71	29
Rabies Surveillance	32,917	80,432	1,430,693	74	26
Arbovirus Surveillance	282	5,024	136,300	75	25
Rodent Control	2,607	140,704	630,274	79	21
Arthropod Control	544	2,859	88,399	68	32
Water Pollution	1,616	16,851	630,829	78	22
Air Pollution	1,901	22,637	531,057	51	50
Radiological Health	3,863	6,957	497,379	68	32
Toxic Substances	5,058	12,805	477,816	78	22
Vital Statistics	145,555	513,738	2,416,945	51	48
Subtotal	1,261,936	4,417,125	51,789,492	71	29
Personal Health					
Cardiovascular Disease	28,523	48,030	1,124,933	63	37
Hypertension	141,936	300,515	1,796,961	61	39
Diabetes	32,872	71,962	944,598	64	36
Cancer	18,159	31,801	711,326	58	42
Home Health	4,558	82,509	2,399,812	49	51
Health Risk Reduction	8,640	38,080	743,162	67	33
Nutrition	38,195	63,982	1,132,936	45	55
WIC	109,446	1,102,945	6,210,371	93	7
Family Planning	140,523	638,910	13,115,475	71	29
Maternal Health/IPO	42,811	497,470	13,669,851	69	30
Child Health	219,513	905,236	16,500,286	69	31
School Health	955,757	3,796,796	11,853,269	61	39
Adult Health	394,141	830,059	6,267,155	66	34
Dental Health	208,561	453,165	4,697,487	55	45
Subtotal	2,343,635	8,861,460	81,167,622	68	32

Primary Care					
Child Primary Care	7,691	25,833	1,508,046	85	15
Adult Primary Care	37,327	94,349	3,082,108	11	89
Subtotal	45,018	120,182	4,590,154	35	65
Grand Total	3,650,589	13,398,767	$137,547,268	68	32

Source: Third Annual Report: Florida Public Health Unit Subcouncil, July 12, 1985.

Table 2. — Categorization of CPHU Primary Care Proposals.

Ranking		County	Requested	Approved*	Status
Category 1	1.	Madison	$ 159,500	$ 191,306	Operational 3/15/85
	2.	Sumter	340,030	340,030	Operational 5/1/85
	3.	Washington/Holmes	445,639	334,808	Planned start-up 7/15/85
Category 2	1.	Broward	1,345,145	1,569,310	Planned start-up 6/10/85
	2.	Dade	1,957,624	2,000,000	Operational 5/1/85
	3.	Dixie	474,031	395,772	Planned start-up 7/15/85
	4	Duval	1,513,215	1,546,763	Operational 4/15/85
	5	Jefferson	224,193	237,285	Planned start-up 6/15/85
	6.	Lafayette	194,202	138,378	Operational 5/1/85
	7.	Pinellas	1,250,000	1,047,000	Planned start-up 6/15/85; additional program 10/1/85
	8.	Putnam	342,000	371,000	Operational 4/1/85
Category 3	1.	DeSoto	275,300	326,663	Planned start-up 6/28/85
	2.	Escambia	1,245,995	292,536	Planned start-up 6/28/85
	3.	Hardee	132,998	234,029	Planned start-up 6/28/85
	4	Monroe	1,630,927	292,536	Planned start-up 6/28/85
	5.	Pasco	552,750	243,781	Planned start-up 6/28/85
	6.	Volusia	983,183	438,803	Planned start-up 6/28/85
	1.	Alachua	228,689		
	2.	Brevard	516,549		
	3.	Gilchrist	227,317		
	4	Hillsborough	904,997		
	5.	Highlands	379,800		
	6.	Indian River	427,764		
	7.	Lake	535,986		
	8.	Lee	1,221,731		
	9.	Leon/Wakulla	1,294,002		
	10.	Manatee	540,478		
	11.	Martin	250,000		
	12.	Okeechobee	354,123		
	13.	Orange	802,116		
	14	Palm Beach	640,000		
	15.	St. Lucie	371,329		
	16.	Seminole	253,403		
Total 35			$22,015,016	$10,000,000	

*10/1/85 to 9/30/86

NOTE: Categories refer to the extent to which revisions in proposals were needed prior to funding approval.

Source: Third Annual Report: Florida Public Health Unit Subcouncil, July 12, 1985.

1. The program should provide a comprehensive mix of preventive and illness care services;
2. The program should be family oriented and be easily accessible regardless of income, physical status, or geographical location;
3. The program should ensure 24 hour access, and offer evening and weekend clinic services;
4. The program should offer continuity of care over time;
5. The program should ensure access to specialty care and hospitalization, if required;
6. The program should make maximum use of existing providers to ensure efficient use of resources;
7. The program should have a sliding fee schedule for patients above 100% of the federal poverty level;
8. The program should include quality assurance provisions and procedures for evaluation; and
9. The program should not pay for hospitalization.[11]

This is not to say that patients would not be referred to hospitals or that hospitals would not be a component of the comprehensive plan for indigent health care. Rather, provisions stress that payment for hospital care should not come from the $10 million earmarked for primary care but from sources such as Medicaid or other funds available within the Public Medical Assistance Trust Fund.

This indicates further that the county public health unit care program is to emphasize primary outpatient care involving preventive medicine, health education, and other public health features such as nutritional guidance, family planning, and improved pregnancy outcome. Yet coordination with hospitals for inpatient services was designed to be essential to assure continuity of care. University Hospital of Jacksonville, for example, is a teaching hospital under auspices of the University of Florida and is a key element of the Duval County Public Health Unit's primary care program. The Palm Beach County Public Health Unit's primary care proposal was not initially approved but it has been providing primary care services in conjunction with inpatient hospital services on a contractual basis to the indigent for many years. Since 1981 the Unit has been providing a prepaid health plan on contract with the Medicaid Office of the Department of Health and Rehabilitative Services. The plan offers a comprehensive range of services and encompasses a network of over 55 private physicians and other allied health personnel and agencies.[12]

The Subcouncil's report established the central theme and direction for the county public health unit primary care plan. "The public health delivery system," the report states, "should gradually expand to become the 'medical home' for individuals and groups who are unable to access comprehensive preventive care and illness services".[13] The report envisions the following system: "CPHUs (county public health units) would become the agency responsible for ensuring that the medical needs of the clientele are met, either by providing services directly or acting as the client's broker to obtain such services from other public and private providers. In addition to offering a set of specific clinic services, the role of the CPHU would be expanded to include comprehensive medical management with a heavy orientation to early detection and prevention. CPHU core staffing would likewise be expanded to include personnel skilled in diagnosis, development of treatment plans, and leveraging service providers in the community who can deliver those services not available in the CPHU. Priorities for new funding would be directed at filling existing gaps in the CPHU service mix and enabling the CPHU to exercise its expanded role through new staffing or purchase of service capability. CPHUs would become primary care agencies distinguished by their attention to prevention and to provision of a comprehensive, continuous pattern of care."[14]

The $10 million originally targeted for primary care through county public health units from the Public Medical Assistance Trust Fund was not tied to the specifics of what constitutes a primary care program or the criteria for being an enrollee. However, the Health Care Access Act includes provisions that expanded Florida's Medicaid program to new categories set at 133⅓% of the payment standard for AFDC (Aid to Families with Dependent Children) eligibility and called for the Department of Health and Rehabilitative Services to study the feasibility of using monies available in the Fund to reimburse hospitals for uninsured patients certified to be below the federal poverty level. The Act generated the study by the University of Florida Center for Health Policy Research on contract with the State of Florida's Hospital Cost Containment Board to determine the extent to which bad debts reflect the provision of care to the medically indigent (the uninsured and non-Medicaid eligible), current methods of financing indigent care including ad valorem taxes and state taxes, and proposals for broader-based funding sources to finance indigent health care.

The traditional role of public health and the role anticipated for it under provisions of the Burnsed Act with regard to primary care was that through prevention and early intervention in the disease process fewer indigents would ultimately need to be hospitalized. Emphasis on primary care was thus intended to reduce the burden of hospitals for uncompensated or undercompensated care caused by the acutely ill indigent.

Providers and brokers of health care • The Health Care Access Act, under section 11 of Chapter 84-35, Laws of Florida, created section 381.025, Florida

Statutes, which was codified within the principal public health chapter of Florida statutory law. Section 381.025(1), Florida Statutes, as established by the Health Care Access Act, further mandated long-range planning by the Department of Health and Rehabilitative Services for the general health and well-being of the citizens of Florida. By statute, therefore, that responsibility was placed by the Health Care Access Act under auspices of Florida's public health system.

Section 381.025(2), Florida Statutes, also created by the Health Care Access Act, specifically directed the Department of Health and Rehabilitative Services to improve the health status of the children in Florida through expanded pediatric primary care and dental care capabilities. It further charged the Department to maximize the use of its health care dollars by targeting resources for primary and preventive care.

These provisions, when taken alongside the primary care provisions of the Burnsed Act of 1983 and the initial primary care funding authorized by the Health Care Access Act of 1984, provide strong legislative intent and historic direction toward expanding with increased funding the concept of county public health units as providers and brokers of primary care, all working in concert with private and other public providers in order to meet the complex health exigencies of Florida's large indigent population.

Conclusion ●It is in the best interests of the private sector of medicine to enhance the ability of the state's public health system, serving as an agency of county and state government and entrusted with public funds, in the provision of services to indigent patients either directly or brokered to private providers. As Frank A. Sloan, Ph.D., Professor of Economics and Director of the Health Policy Center at Vanderbilt University, articulated so aptly: "If competition is to mean that millions of the poor will be unserved, there is likely to be such a backlash in favor of new regulations that competition in health care will soon be an idea whose time has come and gone."[15]

It is time indeed for the public and private sectors of medicine to strengthen their ties upon the firm foundation of their mutual and historic relationship in the field of public health. As public health turns to meet the health care needs of the indigent, so too must all organized medicine by building upon proven existing systems of care while making them accessible to those who need them most. In the case of the indigent, this accessing to care will require the combined effort and enlightened leadership of every public and private practitioner of medicine in this state. Such an endeavor is both a challenge and an opportunity for a better future in a competitive environment in which we all must share the art of living well.

Acknowledgment

Appreciation is extended to John F. McGarry, M.D., M.P.H., Director, Orange County Public Health Unit, and Chairman, Florida Public Health Unit Subcouncil; Carolyn Hall, M.L.S., Associate University Librarian, Borland Health Sciences Library, incorporating the State of Florida Public Health Library; State Epidemiologist E. Charlton Prather, M.D., M.P.H; Patricia C. Cowdery, M.D., M.P.H., Director, City of Jacksonville Department of Health, Welfare and Bio-Environmental Services; C.L. Brumback, M.D., M.P.H., Director, Palm Beach County Public Health Unit; and James K. Conn, M.D., Chairman, Subcommittee on Government Programs, Florida Medical Association.

References

1. An Opportunity for Leadership: Report and Recommendations of Florida Task Force on Competition and Consumer Choices in Health Care, Office of the Governor, March 1984.
2. Section S, Chapter 84-35, Laws of Florida.
3. Louis Harris and Associates: Medicaid and Indigent Health Care Survey and Cost Estimation Study conducted for the Florida State Department of Health and Rehabilitative Services, New York, 1985, p. 6.
4. Woodruff, T.M.: Florida House of Representatives, 58th District, Press Release, September 13, 1985.
5. Hardy, A.V., and Pynchon, M.: Millstones and Milestones; Florida's Public Health from 1889, Florida State Board of Health Monograph Number 7, Jacksonville, 1964, p. 68.
6. Section 154.01(3), Florida Statutes.
7. Section 154.01(2)(a), Florida Statutes.
8. Section 154.01(2)(b), Florida Statutes.
9. Section 154.01(2)(c), Florida Statutes.
10. Section 9(5), Chapter 84-35, Laws of Florida.
11. Third Annual Report: Florida Public Health Unit Subcouncil, Department of Health and Rehabilitative Services, July 12, 1985, p. 33.
12. Evaluation of the Palm Beach County Prepaid Health Plan, Office of Evaluation, Department of Health and Rehabilitative Services, February 2, 1983.
13. Third Annual Report: Florida Public Health Unit Subcouncil, p. 39.
14. Third Annual Report: Florida Public Health Unit Subcouncil, p. 39.
15. Sloan, F.A.: Presentation to Florida Council of 100, Spring, 1985.

● Mr. Jackson, Florida Medical Association, Inc., P. O. Box 2411, Jacksonville 32203.

Development of the Florida County Public Health Unit System

David L. Crane, M.D.



A major victory may be snatched from the verge of a great defeat. Such was the case in Florida in 1888. One of the state's developing urban communities and a major seaport, Jacksonville, was faced with disaster. Almost half its residents fled in panic while nearly 50% of those who remained were directly involved. A hurricane of severe proportions? No, a disease caused by a virus and transmitted by a mosquito — yellow fever. Nearly 9% of those attacked died and mortality was contained at this level primarily due to the good medical and nursing care provided by volunteers from throughout the state.

This was neither the first nor the last yellow fever epidemic to occur in Florida but it was the most serious. It clearly demonstrated that Florida lacked a cohesive system of public health services that could be mustered in time of need to protect and assist those threatened by a disease outbreak. As a direct result the newly elected governor, Frances P. Fleming, as one of his first official acts, convened a special legislative session in the spring of 1889 which created the Florida State Board of Health. Dr. J. Y. Porter, a valiant and able Florida physician who had come from Key West as a volunteer to assist in combatting the epidemic, was selected as Florida's first State Health Officer, a position he held for 28 years.

Prior to establishment of the Florida State Board of Health, there had been several so-called County Boards of Health established by county ordinance. However, these were primarily political rather than health organizations and they dealt more with commercial than with health interests. After several years these County Boards were abolished by the legislature to be replaced by "county agents," local physicians who looked after health matters and reported on a regular basis to the State Health Officer. While the State Health Officer received a salary of $3,000 per annum the county agents received $15 each day when engaged in providing health services in the counties.

A smallpox epidemic in 1912, in which more than 3,000 cases were identified, gave further impetus to broaden the authority, responsibilty and scope of the State Board of Health. The Board petitioned the legislature was slow to appreciate the real need, continuous pressure by Dr. Porter and other concerned forts to control the spread of disease. While the legislature was slow to appreciate the real need, continuous pressure by Dr. Porter and other concerned physicians from throughout the state, led to an increase in funds for tuberculosis, diphtheria and hookworm control programs. Physicians from all areas participated in these programs at minimal cost.

The Author
DAVID L. CRANE, M.D.
Dr. Crane is Senior Physician at the Seminole County Health Department.

These were the first steps toward development of local pressures for expanded public health services at the grass-roots level.

Enabling legislation • One of Dr. Porter's most energetic aides was Dr. George Dame who had assisted the state office as a county agent. He was later appointed, on a part-time basis to serve a district composed of several rural counties. Dr. Dame and Dr. Porter were equally convinced that Florida needed a valid system of county health units and as early as 1921 Dr. Dame started work on a proposal to initiate such coverage. Unfortunately these were depression years and all health work was curtailed. Therefore, ten years passed before the legislature could be prevailed upon to pass enabling legislation allowing the establishment of county health units. This legislation, Chapter 154, Florida Statutes, still constitutes the keystone of the county health unit system. This law permits each county to establish, under the supervision of the State Board of Health, a local county health unit. The basic staffing of such a unit is to consist of a physician, nurse, sanitary officer and clerk. All such personnel were expected to have special training in public health and all were subject to the rules and regulations of the State Board of Health, supplemented by such rules and regulations as might be required by local ordinances of the county governments. Provisions are made in the law for the state to allocate funds to the counties to help in support of the public health program and to provide other direct service support such as state laboratory services. Allowance was also made for several small counties to cooperate in a joint-endeavor unit where personnel could be shared across county borders and thus provide more complete service than the individual counties might be able to provide alone.

This law, perhaps as much as anything else, due to its permissiveness, has led to establishment of a county public health unit in each of the state's 67 counties. This was accomplished in a period of 29 years while many states in the nation still have not achieved such coverage. Much of the impetus of this development may be ascribed to the dedication and diligence of Dr. Dame and to the support he received from Florida's physicians who believed in strong local health controls. Taylor County was the first to establish a health unit in late 1930 and the Leon County unit was opened in early 1931. Within ten years of the enabling legislation 35 counties had established health units. By 1945 there were 43 operating units employing 26 physicians, 166 nurses, 99 sanitarians, 104 clerical workers and 34 others including health educators, nutritionists, clinic aides and support personnel. Approximately 75% of the people in the state were served by their own local health unit. In 1945 less than $1 million was expended by these health units and over 60% of the funds came from the counties while the state contributed about 20%.

Great advances were made in the mid-30s as federal support programs came on line. The Shepherd-Towner Act of 1932 provided funds for maternal child health. The Federal Emergency Relief Administration of 1933 provided funds for general public health nursing for the poor, and the Social Security Act of 1935 funded general public health services to the poor. Had it not been for these federal funds, county health units would surely not have grown so rapidly nor provided so much service to people in need. The push to establish statewide coverage through county public health units was completed in 1960 when St. Johns County established the final unit.

Commonly asked questions • During these developmental years the most commonly asked questions were, "What is public health?" and "What will a county health unit do for the people of this county?" These were logical questions and warranted a reasonable response. The response was: public health is the art and science of preventing disease, prolonging life and promoting physical and mental efficiency through organized community efforts. In spite of all the advancements in science and technology over the past 50 years, this definition still covers this special area of medicine about as well as any that comes to mind. To respond to question number two the community was told: your county health unit will serve you by controlling communicable diseases, providing direct preventive health care to expectant mothers and their children, educating the public in matters related to health, collecting vital statistics within the county, assisting the public in preparing more nutritious food for the family, supervising the cleanliness of water and food utilized by the people, controlling the disposition of solid and liquid human wastes so as to prevent potential disease hazards from developing, and serving as the clearinghouse for health problems within the county. Some of these services would be performed through inspection and licensure of the purveyors of public services and commodities while others would be provided through clinic services to the public and visits to the schools, homes and businesses of the community by trained public health workers. Together the community leadership, people and health unit staff would cooperate in ensuring a healthful environment and improved health conditions for all.

In 1985 the budget for public health in Florida was slightly in excess of $100 million. Approximately one half of this sum was expended for operation of county public health units. More than half these dollars came from the counties for support of their own units. It is quickly apparant that the legislators who wrote the enabling legislation over 50 years ago were very wise. Local contributions to public health have grown over the years to keep pace with local

growth and the county public health units have become a very productive and vital service for Florida's year-round residents as well as its millions of winter visitors.

Public health is the sum total of the health of the people of Florida. The nation's strength lies in the health of its people. The county public health unit's single purpose is to maintain and improve the health of all the people.

- Dr. Crane, Seminole County Health Department, 240 W. Airport Blvd., Sanford 32771.

The great typhoid epidemic in Florida, 1898

William M. Straight, M.D.

Private Willie Smith was one of the fatalities at the Third Division Hospital, Tampa, Florida, in 1898. His death was recorded as due to the "army fever" but the chief surgeon, Major Robert P. Izlar, later thought the true diagnosis was typhoid fever. Major Izlar performed an autopsy and found "tumefaction and ulceration of Peyer's patches and enlargement of the mesenteric glands."[1]



Smith was an enthusiastic farm boy caught up in the national furor to drive the oppressive Spaniards out of Cuba. He enlisted in his home town and was sent to Camp Chickamauga, Georgia. After three weeks there he entrained with his unit for Tampa, the port of embarkation. He blithely looked on this war as a fun-filled adventure that would be over in a few weeks and hoped he would not be too late for the action.

The many hours on the train dampened his enthusiasm but did not extinguish it. The weather was hot and his sweat-soaked blue woolen uniform very uncomfortable. The coach windows, open to capture whatever wind stirred, let the black smoke of the wood-burning engine cover everything with soot and stifle the occupants of the coach. Drinking water was scarce and food almost unobtainable during the trip.

Smith had not been well for three days prior to entrainment. He felt lethargic, lost is appetite and his sleep was tormented and restless. Shortly after boarding the train he became feverish, achy and lightheaded. A dull, generalized, continuous headache and mild nausea plagued him. He attributed these symptoms to the heat and the smoke that poured into the coach.

The following day he felt no better and when the train finally stopped at Tampa he was barely able to complete the two mile hike to Port Tampa City where his unit was to camp. His buddies pitched a tent and spread a blanket for him and, not missed in the confusion of setting up camp, he drifted off to sleep. That night explosive diarrhea routed him three times. He had no time to look for a latrine so slipped into the woods behind his tent and relieved himself. On the second day he was too weak to report to morning roll call. His sergeant notified the regimental surgeon who saw him briefly and arranged for the litter bearers and ambulance to take him to the division hospital.

An assistant surgeon at the hospital saw him soon after he arrived and commented upon his pallor, furred tongue with red borders, dicrotic pulse, mildly distended and tender abdomen, possible left upper abdominal mass, low grade fever and several curious rose-colored spots over the abdomen. Smith appeared to have the same illness that the surgeon had been seeing frequently and which had been labeled "army fever." Privately the surgeon thought Smith would ultimately show the typical signs of malaria, but one must also consider dengue fever, dysentery, typhoid

The Author
WILLIAM M. STRAIGHT, M.D.
Dr. Straight is a practicing internist in Coral Gables and former Historical Editor of The Journal. He has published thirty-three articles on Florida medical history.

fever and the dread yellow fever that was known to occur in tropical climates such as Florida.

The surgeon's initial therapy was seven and one-half grains of calomel followed in an hour by a heavy dose of epsom salts. Along with this, to serve as an intestinal antiseptic, he gave salol (phenylsalicylate) ten grains and carb. guaiacol ten grains every two hours around the clock. For sustenance Smith was given milk, beef broth and weak tea as much as he could take.

On the second hospital day Smith's temperature began to spike to 104 degrees in the afternoon and his pulse became weak and thready. As stimulants the surgeon prescribed strychnine 1/30th grain every four to six hours as needed and two ounces of whiskey every four hours. To control the pesky diarrhea, he was given frequent doses of milk of bismuth. To reduce the abdominal distention turpentine stoops were placed on his abdomen for 20 minutes every four hours.

Smith's response was poor with the fever continuing to reach 102 to 104 degrees each afternoon, now ten days after he had entered the hospital. To combat this fever Smith was given phenacetine and was sponged with ice water sometimes for an hour at a time. This procedure, one might think, would feel pleasant but quite the contrary, the shock was painful and Smith begged that it not be done.

His headache had disappeared but was replaced by a mental torpor interspersed with short periods of delirium. During the night following the tenth hospital day in a period of delirium he got up, staggered a few yards down the company street and collapsed. Alerted by the shouts of other patients the hospital stewards carried him back to his cot. Barely on the cot he suddenly loosed a large, bloody, involuntary stool and lapsed into unconsciousness. The assistant surgeon, routed from his tent nearby, came quickly and gave a subcutaneous injection of ether followed by fifty milliliters of normal saline solution intravenously. Nothing availed, the pulse became impalpable and Smith ceased to breathe at four in the morning.

War with Spain • In 1895 Cuban insurgents revolted against the inept rule of Spain. In need of guns and ammunition, junta leaders came to the United States to appeal for support to the Cuban exiles living here and to political leaders of this country. This happened just at the time Joseph Pulitzer's *New York World* and William Randolph Hearst's *New York Journal* were engaged in a struggle for circulation supremacy. Tales of Spanish atrocities in Cuba were ready-made eye catchers, particularly if embellished a bit. What could be more appealing to the freedom loving citizens of this great country!

These two newspapers and others throughout the country seized the opportunity and daily treated their readers to inflammatory headlines in the best tradition of "yellow journalism." The Spanish commander of the military government, Captain-General Weyler, was labeled "Butcher Weyler, the devastator of haciendas, the destroyer of families, and the outrager of women." Cuba was pictured as a land in which the blood of innocent men, women and children flowed in the streets. Under this daily propaganda bombardment a clamor arose to free the Cuban people from Spanish oppression. President McKinley and the Congress tried to move slowly and cautiously. Then on February 15, 1898, the battleship Maine blew up in Havana harbor and the public clamor rose to fever pitch, aided to no small degree by the press. McKinley declared war with Spain on April 22, 1898, and thousands of eager young men trooped to the colors. In a matter of weeks the Army expanded more than one hundred fold, from 26,000 men to 273,000 men. Congress, underestimating the costs involved, was slow to provide the necessary funds. Indeed only $20,000 was initially allotted for expansion of the



Fig. 1. — Second Illinois in camp at Jacksonville (Harper's Weekly, July 2, 1898).



Fig. 2. — Field surgical ward, 1898 (Harper's Weekly, Sept. 17, 1898).

medical department. Despite this lack of support, the Medical Corps with 177 surgeons and less than a six month supply of material in its supply depots had to match this expansion of the Army. This was accomplished by adding hundreds of surgeons from the volunteer units, contract surgeons from civilian life, and men detailed from the ranks to serve in the Hospital Corps as nurses. The Medical Corps struggled to indoctrinate these new personnel in the ways of Army life and at the same time provide for the health of hordes of raw recruits. As would be expected, there were many failures and shortcomings which provided more fodder for the ever vigilant newsmen who infested the Army encampments.

As preparation for war began it was decided that Tampa would be the port of embarkation for Cuba. This port was much closer to Cuba than Pensacola, Mobile or New Orleans, had a deep and sheltered harbor, and was serviced by two railroads. As a consequence the largest number of troops in Florida were encamped there awaiting transportation to Cuba. Lesser numbers were camped at Jacksonville (Camp Cuba Libre), Fernandina, Miami and Lakeland. Key West was primarily a naval base although the Army had a post and a small post hospital as well as a general hospital there. The general hospital, also known as the Convent Hospital, received casualties from the battlefields of Cuba. On Egmont Key near Tampa the Army had a quarantine camp to which some of the sick and wounded were brought from Cuba and held until it was thought safe to send them to general hospitals on the mainland.

As in all wars, in this "splendid little war" as styled by the Secretary of State, John Hay, disease killed many more than bullets. The generally accepted statistics in this matter are those of the Surgeon-General.[2] The period covered is May 1, 1898, to April 30, 1899. Deaths from disease were 5,438 and deaths from battle wounds, injuries and accidents 968.

Perhaps the single most operative factor in this high disease and death rate was the haste with which the troops were assembled and encamped. There was simply not enough time to prepare for them. This was especially true for the estimated 100,000 men who streamed into the Florida encampments. Dr. Scheffel H. Wright in an excellent article on the medical aspects of this war,[3] portrays this graphically:

> Tampa was selected as a campsite on April 15, 1898, and next day the first contingent of troops arrived after many hours without food or drink. Barely had the train coaches stopped when the troops were ordered to fall in and march from Ybor City to the campsite to Tampa Heights. About half the soldiers were unable to complete the march because



Fig. 3. — Infantry in camp, Tampa, 1898 (Harper's Weekly, May 7, 1898).

of heat stroke. Half-starved, dehydrated soldiers from the North clad in woolen uniforms were no match for the Florida sun. . .As the troops began to increase in number, camps were located at DeSoto Park, Palmetto Beach, Port Tampa and behind the Tampa Bay Hotel. The city extended municipal services such as sidewalks, electric power lines, sewer mains and trolley lines to some of the camps, but on May 31, the Florida State Board of Health stopped sewer construction "as it was customary to prohibit any opening of the soil during the summer months." This prohibition was based on the maismatic theory of disease propagation which was in vogue at that time. According to this theory, earth newly turned in the summer gave forth noxious effluvia capable of producing fevers such as malaria and yellow fever.

In Florida the major problems engendered by the haste of assembly and encampment of the troops were provision of adequate food supply, water supply and human waste disposal.

Food and water • The soldier of this war was a beef and bacon eater. His daily ration supposedly was: 12 ounces of bacon, pork or canned beef, or 20 ounces of fresh beef, if it could be had, 18 ounces of soft bread or 16 ounces of hard tack, plus beans or peas, rice or hominy, coffee, sugar, pepper and vinegar. Although a thriving cattle industry had existed in Florida since before the Civil War, the output was not sufficient to supply the large number of soldiers. To supplement the local supply, beef was shipped from the midwest in refrigerated railroad cars. At times refrigeration failed and beef spoiled. At least occasionally such tainted beef inadvertently got on the soldiers' plates. Canned beef, which had been used as Army fare in transit since 1878, was at times pressed into service and was a cause of much complaint from the troops. They found it stringy, gristly, unpalatable and at times nauseating. No less a personage than Carl Sandburg who was a private in this war gives a graphic description of this delicacy and the soldiers' nickname for it, "Red Horse."

A brief experiment was carried out by one of the meat packers in which an attempt was made to preserve beef by injecting it with certain chemicals. This was seized upon by the war correspondents and led to much newspaper coverage under headlines such as "The Embalmed Beef Scandal." Although in actual fact none of this treated beef was ever served to the troops, Major-General Nelson A. Miles stated emphatically that the troops were served chemically treated beef "which you might call embalmed beef," and that he had it on good medical authority that "chemicals were largely responsible for the sickness in the army."[4] Although spoiled food must have accounted for some of the sickness during this war, it was never proven to be a significant source of morbidity or mortality.

Providing adequate quantities of safe and palatable water to the troops in Florida was a major problem. At the time of the Spanish-American War



Fig. 4. — Soldier in full dress, 1898 (Courtesy of the Historical Museum of Southern Florida, Miami).

it had been well established that contaminated water supplies could carry disease, particularly typhoid fever. Therefore, early in the mobilization Surgeon-General Sternberg sent out a directive that all water used for drinking or cooking purposes should be boiled; however this directive was largely ignored by the line officers and soldiers alike. At Tampa three sources of water were in use: water from artesian wells already used by the city, water brought in by railroad tank cars, and shallow wells providing surface water that were installed by individual batallions and were often near company latrines.

Almost all the water at Jacksonville came from artesian wells and was thought to be the safest of any used in the Florida camps. However the Jacksonville water had a high sulfur content which was objectionable and led some to believe it ". . .does not agree with some of the men; it brings on fever. Our surgeon says that he believes that the water has given the men typhoid fever. . ."[5] Still another, although unauthorized, source of water was shallow wells put down near the shacks of refreshment vendors near the camp. As

the number of fever cases rose in the camps of Jacksonville, these vendors were prohibited and their wells destroyed.

At Miami, in preparation for the coming of the troops, Henry Flagler's superintendent cleared a campsite and put down a number of shallow wells equipped with pitcher pumps. In addition they laid pipes along the surface of the ground to further supply the camp with water from the Miami city water system. This water was pumped from the edge of the Everglades four miles west of the city. It was highly colored, had a decidedly marshy odor and came from the taps about 15 degrees warmer than the water from the pumps. As might be expected the soldiers preferred the pump water. As the number of the sick increased, the shallow wells were suspected of contamination and the pump handles ordered removed. An attempt was made to make the city water more acceptable by running the pipes through barrels of ice but this was only minimally successful.[6] Despite the complaints of the soldiers and the suspicions of the Army surgeons, after a careful investigation of the water supplies, in no instance was it proven that disease was transmitted by the water supply in any of the Florida camps.



Fig. 5. — Surgeon's undress uniform, 1898 (Harper's Weekly Supplement, June 25, 1898).

Human waste disposal ● Far and away the most difficult problem, the problem that was never satisfactorily solved, and the problem that caused most disease was the matter of human waste disposal. The rapid influx of troops precluded provision for adequate sewage disposal in most of the camps. The thin layer of surface soil at Tampa and Miami and the high water table in these areas made the standard Army latrine system largely unworkable.

Captain J.L. Burkhardt, medical officer of a unit encamped at Palmetto Beach in May 1898, vividly describes the problem at Tampa:

> When we first arrived at Tampa we were able to dig the sinks about three feet deep before striking water, but after it began to rain and during the last few weeks of our stay we could not dig six inches into the ground without striking water. There was an order to throw dirt into the sinks. In the first place we could not dig and in the second place we had no dirt to throw into them. The sinks overflowed, but the fecal matter was carried in the opposite direction from the regimental camp. The space between the sinks and the bay was covered with fecal matter. Flies swarmed over these deposits not more than fifty yards from the kitchens and mess tents.[7]

Lieutenant Joseph W. Bauman encamped at Port Tampa states they attempted to throw large quantities of paper into the sinks and ignite them. This seemed to disinfect the sinks but caused a horrible odor to rise over the entire camp.[8] At Tampa and in the other Florida camps orders were for the soldier to cover his own excreta with dirt or chloride of lime at the time of evacuation. Soldiers were careless about doing this so in some units guards were placed at the latrines to enforce the order.

At Jacksonville (Camp Cuba Libre) three different systems were in use depending upon where the unit was located. For example, the Third Division was located on high ground with deep sandy soil which permitted latrines to be dug to the depth of seven feet so this division depended entirely on pit latrines. The First Division was encamped on a high bank along the St. Johns River and were supplied with long zinc-lined troughs with a faucet of continually flowing water at one end and an outlet at the other that permitted discharge of the trough contents into sewers and ultimately into the river. However, a goodly portion

of the Jacksonville camp was dependent upon the tub system. This, the most unsatisfactory system of all, was in use to some extent at the other Florida camps and particularly at Miami. Captain Joseph B. Whiting Jr., Assistant Surgeon with the First Wisconsin Volunteer Infantry at Jacksonville, describes this system:

> The evacuations were made in half whiskey barrels located in battalion latrines. . .For the convenience of the men in the latrines there was simply a pole, supported along the edge of the row of tubs, that the men sat upon. There was no arrangement by which at night the men could be guided in the use of the latrine, so that they might place themselves directly over the tub; and it was possible enough, especially in the use of the latrines at night, for the excreta to fall upon the ground between the tubs. These half whiskey barrels had rope handles to them. At first they were changed twice a day, afterwards they used to go two or three days unchanged, and that not very rarely. I have seen these tubs full to overflowing a great many times. . .In lifting the tubs into the scavenger wagons and hauling them away there was a great deal of slopping over of the contents. This slopping over was not only between the sinks and the wagons, but also along the road which the latter traversed. There was no attempt at disinfection of these tubs, except the use of crude or unslaked lime. This would not be put into the tubs until they were returned by the scavenger empty. It would also be sprinkled upon the ground of the latrine. At the division hospital we used some sulphate of iron for a while, and I think they have returned to crude carbolic acid.[9]

At Miami the ground cleared by Flagler's men before the troops arrived lay along the bayfront extending north from the present day Northeast First Street. It was close enough to the water to permit use of the trough system as used at Jacksonville. The contents were to be sluiced into Biscayne Bay. However, when the Division commander arrived in Miami he changed the plan so that only two units were camped along the bayfront and the other four were placed west of these two units, too far from the bayfront to utilize the trough system. This meant the majority of the troops were dependent upon the tub system. The tub system functioned no better at Miami than it did at Jacksonville. Furthermore the slopping on the ground, it was thought, contaminated the water of the previously mentioned surface wells. Then too, at all the camps, the soldiers often took to the woods rather than brave the flies and odors around the tubs. One officer at Miami complained that he could not go more than ten feet behind the last row of tents without soiling his boots with excreta. Lieutenant Colonel Louis M. Maus, Chief Surgeon of the Seventh Army Corps, commented that the men of the First Division, when they moved from Miami to Jacksonville, carried with them the bad habit of relieving themselves "in the woodland adjoining their camp."

Control of insects • Still another problem poorly recognized at the time but in retrospect likely a very important one in spread of disease was the lack of control of insects, particularly flies. As mentioned previously human waste disposal was poorly done in most of the camps and often the latrines were only a short distance from the kitchen and mess tents. Dr. E. M. Nolan, a contract surgeon at Camp Cuba Libre, gave this description of the fly problem at Jacksonville:

> Flies encamped with the soldiers, and increased by the thousands. They swarmed over and upon the excreta in the tubs and sinks. When interrupted, some would, with feet, legs and probosides, and perhaps wings and body carrying typhoid germs, seek new pastures around the company kitchens, the tables of restaurants, the counters of the canteens and the booths. . .they were on the glasses, cups, plates — everything, and of course the food.[10]

Some of the critical newspaper articles mentioned the sick asleep with flies crawling in their mouths. Attempts were made in some of the camps to supply screened quarters, particularly on the hospital wards but wire screening was short of supply. Mosquito netting was acquired but many of the soldiers seemed to prefer the flies to the mosquito netting as the netting cut out what little breeze there might be, making sleep impossible.

Mosquitoes were a problem, especially at Miami. A soldier at Miami commented, "Here at Miami we have heat, mosquitoes and sandfleas that beat anything we have ever met. We even hang our hats on the mosquitoes at night!"[6] Annoying as they were, mosquitoes probably were not a significant cause of the spread of disease in the Florida camps.

Army hospitals • Before proceeding to a discussion of the diseases encountered, let us take a look at the Army hospitals in Florida in 1898. Many of the regiments came to the Florida camps equipped with a regimental tent hospital. However, early in organization of the expanded Army, the order was sent out to abolish regimental hospitals and transfer their equipment to the division hospitals. It seemed common sense that one division hospital could be operated more efficiently than seven regimental hospitals. Regiments were permitted to operate aid stations under the administration of the regimental surgeon and the surgeon, at his own discretion, could keep patients for observation 48 hours. If they remained unable to return to duty in that period of time, they must then be sent on to the division hospital. The order abolishing regimental hospitals did not sit well with volunteer regiments and often soldiers tried to hide their illness rather than be separated from their regiment. Delays thus caused by the soldiers themselves and delays in transfer by regimental surgeons who were slow to recognize the presence of serious disease likely played a part in the spread of illness throughout the Army.

Except in a very few instances the Army hospitals in Florida were tent hospitals. There are references to an Army hospital in a convent building in West Tampa

and at Key Wet the Army maintained the Key West Barracks Hospital and a 500-bed hospital in the Convent of Mary Immaculate. In the Convent Hospital Sisters of the Holy Names of Jesus and Mary served as nurses. In each of these instances hospital tents were pitched on the grounds surrounding the buildings to provide more beds.

The tent hospital consisted of multiple "wards," operating tents, mess tents and kitchen tents as well as tents housing the medical officers, nurses, hospital corpsmen and other personnel.

> The hospital tent is 14 feet long, 15 feet wide, and 11 feet to the ridge, the wall being 4½ feet high. This space will accomodate six hospital field cots, three being placed with heads against each lateral wall, leaving a center aisle or passageway from end to end. The canvas at each end can be swung back allowing of ample ventilation. By placing two hospital tents in line with each other, end to end, but separated by a distance of fourteen feet, this intervening space being roofed in by a hospital tent-fly, fastened with guy ropes, an ideal twelve bed field hospital can be attained. . .[11]

A "ward" often consisted of such a tent-fly-tent structure; at times it was merely a single tent. Ideally such wards were floored with a wooden platform raised off the ground. At times because of haste to provide for the flood of sick soldiers or the delay in obtaining lumber, the wards were not floored. Indeed, sometimes sufficient cots were not immediately available and the sick were forced to lie on the ground. A division hospital was made up of a variable number of these wards and ancillary tents.

The complement of a division hospital was one surgeon and two assistant surgeons. Early in the campaign all nursing was performed by members of the Hospital Corps (all male) and soldiers detailed on a daily basis from the line. Some of the medical officers complained that line officers chose the unruly, lazy and incompetent men of their command to detail for hospital service. Often convalescent patients were detailed to serve in the hospital until they were sufficiently strong to resume full duty.

Although by the onset of this war there were many well-trained and competent female nurses throughout the United States, there were none attached to the Army. Initially, Surgeon General George M. Sternberg thought female nurses were not necessary to the war effort, but as the number of cases of typhoid fever mounted in the camps throughout the country, the need for the well-trained female nurse was evident. Trained female nurses were then hired as contract nurses for general hospitals, division hospitals, post hospitals and regimental hospitals. In all, contracts were made with 1,563 female nurses; 140 contacted typhoid fever and 12 died.

Most of the Army medical officers were loud in their praise of the services rendered by these ladies and their outstanding performance played a large role



Fig. 6. — Surgeons and hospital corpsmen, Convent Hospital, Key West, 1898 (Courtesy of Wright Langley, Key West).

in the subsequent establishment of the Army Nurse Corps. However, some of the medical officers had reservations such as Lieutenant Colonel A. C. Girard, Chief Surgeon of the Second Army Corps who concluded: "As a rule their behavior was satisfactory and their work commendable, but they were an expensive luxury, as they received more wages than the men of the hospital corps, and required much waiting on."[12]

In addition to the contract nurses, nurses were available from the Red Cross. Apparently Red Cross nurses were not welcomed with open arms by all members of the Army Medical Department. When Major Daniel M. Appel, Chief Surgeon of the First Division, encamped at Miami, applied to the Red Cross representative for trained female nurses, he received a telegram from the Chief Surgeon of the Seventh Army Corps to withdraw his request immediately.[13]

The newspapers carried lurid tales of the insufficient number of trained nurses and inadequate nursing care. The Dodge Commission interviewed a number of the trained contract nurses who testified that in some of the hospitals there were as many as one nurse to every three typhoid cases while in others as few as one nurse to every 35 to 50 cases. The 12-hour nursing shift was the custom of that day but at least in the Third Division Hospital at Jacksonville, nurses worked eight-hour shifts.

Shortages of hospital tents, cots, bedding, bedpans, thermometers, dressings and medications also served the newspapers well. Again the haste of mobilization was the chief cause. One representative of the Army and Navy League went to the reporters claiming that two soldiers with typhoid had died because of the lack of bedpans; they had been forced to walk 100 yards to the latrine and died en route.[14] Dr. Lawrence D. Knowles, Surgeon of the 32nd Michigan Volunteers, stated that upon his arrival at the division hospital at Fernandina only five bedpans were available for 156 patients. He requisitioned more from the medical supply depot at Tampa but they did not come. He finally obtained an adequate supply furnished by the ladies of Dayton, Ohio.[15]

Early in the mobilization and before the hospitals of Florida were well organized seriously ill soldiers were sent by train to Fort Thomas, Kentucky or Atlanta and some were returned to their homes. Some of the soldiers for one reason or another were sent to civilian hospitals which were reimbursed by the Army. Thus, St. Luke's Hospital in Jacksonville treated 264 cases of typhoid fever, most of them soldiers, during the summer and fall of 1898.[16] A lady whose son was stationed at Miami stated that rather than send the sick of his command to the division hospital, the commander of her son's unit sent them to "the hotel" and paid for it from the company sick fund.[17] Finally, on occasion soldiers were taken into the homes of private citizens and nursed back to health.

Diseases encountered • Many of the diseases encountered in the Florida camps were those common to all armies. First there were the childhood diseases: measles, mumps, chickenpox and whooping cough. Measles were especially common and accounted for some of the deaths. Catarrhal jaundice (hepatitis Type A or Type Non-A/Non-B, according to our present terminology) was present among the troops at Miami and Jacksonville. Smallpox vaccination had been the custom of the Army since 1812 but it was not always carefully performed and vaccinia was not uncommon in 1898. Venereal disease was very common as prostitutes were available near all the camps. Headlines were made at Tampa when Teddy's Rough Riders tried to rough up the madam of a house of ill repute and she pulled a pistol from her bra and fired on them.

Accounts of heat exhaustion made some newspaper copy. Poultney Bigelow, reporter for Harper's Weekly Magazine, wrote:

> Down here we are sweltering day and night with the thermometer ninety-eight in the shade. . .Here we are thirty days after the declaration of war and not a regiment yet equipped with uniforms suitable for hot weather. . .United States troops sweat night and day in their cowhide boots, thick flannel shirts and winter trousers.[18]

The Army uniform of the day was a jacket and trousers of blue wool with cowhide boots or wound cloth leggings. Contracts were let for cotton khaki uniforms but the war ended before a significant number of the new uniforms could be issued. In an effort to combat heat exhaustion all active work was suspended between 10 a.m. and 4 p.m.

The possibility of an outbreak of yellow fever was greatly feared but the Army in Florida was spared that disaster. Alarm was aroused in Tampa and the state health officer, Dr. Joseph Y. Porter, himself conducted a house to house survey but found no cases. Another alarm came from an inexperienced Navy doctor at Key West when he mistook three cases of dengue fever for yellow fever in mid-August. Without confirmation from more qualified physicians the Navy ordered most of its personnel and many civilian employees aboard ships, weighed anchors and steamed north. Very soon thereafter the Army followed suit. The three sick Marines finally developed the rash characteristic of dengue fever and subsequently about 6,000 cases of dengue appeared in Key West. Meanwhile the Navy had put a number of sick sailors ashore at Jacksonville and a thousand cases developed there.

As soldiers came down with fever spiking to 104 degrees in camps throughout the state, malaria and typhomalaria were commonly recorded diagnoses. It was generally thought that any significant fever in the South was malaria until proven otherwise and that no fever in Florida could be cured without quinine. Although the malaria parasite had been identified in the blood in 1880, there were few technicians who

could perform the test in 1898. The Reed Commission did many smears in cases of active fever at Jacksonville and were unable to demonstrate malaria organisms in a single case. Although they did not carry out studies at Tampa, the Reed Commission, accepting the word of others, stated that there were cases of malaria at Tampa.[19]

Certainly the most frequent diagnoses to appear on the sick reports were diarrhea and dysentery. Probably with some justification these were attributed to tainted food, contaminated water, and the soldiers' habits of frequenting refreshment vendors and saloons outside the camps. Occasional attempts were made to isolate parasites in the stools but none were found. Bacillary dysentery had been described by Shiga in 1897, but technicians and supplies for cultures were not available for these studies in Florida camps.

By far the most frequently fatal disease of the Florida camps was typhoid fever. In 1898 typhoid was endemic throughout the United States[2] and the troops brought it to the encampments. Army medical officers were slow to recognize this disease and mistook it for malaria, typhomalaria, dysentery and other diseases. Indeed, the Reed Commission stated that "Army surgeons correctly diagnosed a little less than half the cases of typhoid fever." From time to time autopsies were done and demonstrated the typical enlargement of Peyer's patches in the distal ileum, often with perforation or hemorrhage. The typhoid bacillus had been isolated from the stool by Ebarth in 1880 but the equipment and technologists capable of culturing stools were not available generally. Widal had discovered the agglutination reaction to the somatic antigen of the bacillus in 1896 but there were few serologists in the United States in 1898 and none in Florida.

When the Reed Commission came to Fernandina and Jacksonville as part of its nationwide investigation into the cause of the typhoid epidemic in the Army camps, the members brought the necessary equipment, supplies and technical help to do malaria smears, the Widal agglutination and cultures of stools, urine and water supplies. They interviewed medical officers, examined typhoid patients and analyzed camp and hospital statistics. They rendered a preliminary report in the spring of 1899 and a full report in 1900.

They found that in more than 90% of the volunteer regiments and all the regular Army regiments cases of typhoid fever developed within eight weeks of encampment. About one fifth of the soldiers in the national encampments developed typhoid fever. Of the typhoid cases the mortality rate was 7.61%, and deaths from typhoid accounted 86.24% of the total deaths in the national encampments. The average incubation period was 10.5 days. They stated emphatically that "Typhoid fever is disseminated by the transference of the excretions of an infected individual to the alimentary canals of others."[20] Although it was well known that typhoid was transmitted by contaminated water and milk supplies, the Reed Commission was unable to show such transmission in the Army camps investigated. The principal source of the typhoid epidemic, they concluded, was "camp pollution." They were able to show the incidence of typhoid was clearly related to the method of "disposing of excretions." The tub system consistently correlated with the highest incidence of typhoid. The organisms, they thought, were transmitted from the patient or excreta to the next victim by poor hygienic practices, flies and possibly in one instance by fecally contaminated road dust carried on the wind to be inhaled by the soldiers and to light upon their food and be ingested. Typhoid bacilluria was known and the Reed Commission thought typhoid might be transmitted by urine soaked clothing or bedding.

The Commission recognized that excretion of typhoid bacilli began soon after infection and before the disease was recognizable by symptoms or signs. They commented that soldiers during this incipient period might unwittingly infect latrines but made no comment about these soldiers passing the disease during this period by unhygienic practices. Members of the Commission observed untrained men from the ranks detailed for hospital duty who handled the bedpans of typhoid patients then, without washing their hands, went to the mess tent and passed food at the table and fed themselves. The Commission pointed out that the detailing of untrained men from the ranks for hospital duty systematically spread typhoid through the camp.

The presence of typhoid bacilli in the stools of convalescent patients was unknown at the time and the existence of the carrier state was not discovered until nine years after the war. The Commission did comment upon the character of the fever in typhoid being remittent and recognized that the unwary surgeon might return a man to his unit prematurely upon remission of the fever only to have symptoms recur. This would result in exposure of the man's unit. Also misdiagnoses of typhoid as malaria and other diseases might unintentionally contribute to the spread of typhoid. Not knowing of the continued passage of bacilli in the convalescent period and existence of the carrier state, the Reed Commission failed to mention the evils of the practice of assigning convalescent soldiers to hospital and kitchen duty.

It is impossible to arrive at reliable statistics concerning the incidence of typhoid fever and typhoid deaths in the Army camps and civilian population in Florida in 1898. To begin with laboratory medicine was in its infancy and the Army surgeon as well as the civilian physician was dependent upon clinical impression for diagnosis. As mentioned, the Reed Commission concluded that the Army surgeons correctly diagnosed a little less than half the typhoid

cases. It is likely that civilian physicians had no better success, if as good. Furthermore we have the statement that carly in the mobilization seriously ill soldiers werc put on trains and sent to Atlanta, Fort Thomas, Kentucky or to their homes.[21] It is likely some, if not most, of these were typhoid and should be counted in the Florida statistics. Finally, in general, records werc poorly kept as the volunteer medical officers resented paperwork as keenly as many of today's doctors.

If wc accept Surgeon-General Sternberg's statistics that between May 1, 1898, April 30, 1899, 5,438 soldiers died of disease and we accept the estimate of the Reed Commission[22] that typhoid fever accounted for 80% of the total deaths, and assuming that the commission meant "total disease deaths," then during this period there were 4,350 typhoid deaths. It is uncertain how many of these deaths occurred in Florida; however, Table 1 compiled from the meager Army statistics gives the available information on typhoid deaths in our state.

If wc accept the belief of the Reed Commission that less than 50% of the typhoid cases were correctly diagnosed, perhaps we should double this figure and arrive at a total number of typhoid deaths in Florida among the Army personnel as 618.

Typhoid among civilians • In view of the typhoid epidemic raging in the nearby Army camps, it is only reasonablc to assume that the disease spilled over into adjacent towns and cities; however, one searches long and hard for evidence in Florida newspapers or reports of the boards of health, state and local. Perhaps, as some have suggested, this was a deliberate effort by the news media and health officials to protect the healthy image of the state so that tourists would not be frightened away.

Whatever the reason, testimony before the Dodge Commission and the Reed Commission establishes a rise in typhoid fever among the civilians in Florida in 1898.

In August 1898 the *Miami Metropolis*, Miami's leading newspaper, boldly stated: "Miami water does not produce typhoid fever among its own citizens!"

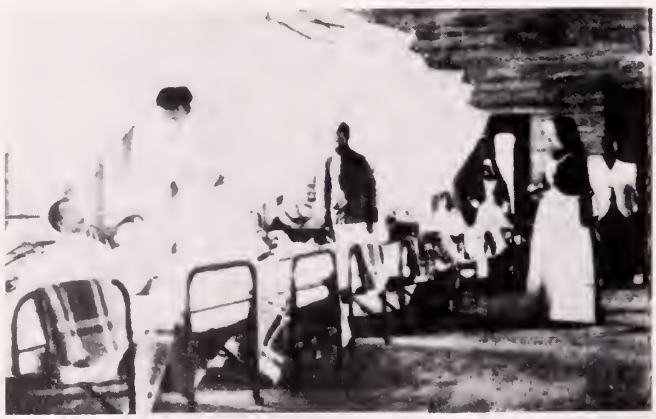


Fig. 7. — Sailor's ward, Convent Hospital, Key West, 1898.

Table 1. — Army Statistics on Typhoid Deaths, May 1, 1898 — April 30, 1899.

Campsite	Deaths From Typhoid
Tampa	46
Jacksonville	248
Miami	12
Lakeland	3
Total	309

However, Colonel Louis M. Maus, who visited the Miami camp during that month, told the Reed Commission, "there is a great deal of typhoid fever among the negros (at Miami)."[23]

Although nothing appears in the newspapers of Tampa about civilian typhoid, a Tampa resident, who seemed to be in a position to know, told the Dodge Commission there were 50 cases of typhoid among civilians in Tampa in August 1898. Furthermore, Assistant Surgeon Charles H. Castle, speaking to the Reed Commission[24] quoted a civilian physician at Tampa as saying Tampa was overrun with typhoid. This physician cited as evidence ". . . the large number of funerals occurring daily."

The Jacksonville City Board of Health stated that the civilian death rate from typhoid and other fevers rose from 22 in the 1897 to 60 in the 1898. It also noted that 94 civilians had died in Jacksonville during 1898 unattended so that the cause of their deaths was not known. Yet the city health officer, speaking of the year 1898, emphatically stated that Jacksonville had been fortunate in "not being visited by any serious epidemic of any kind whatsoever during the year."[25]

Many lessons were learned from the disease experience in Florida and camps elsewhere during the Spanish-American War that were to serve the nation well 18 years later with onset of World War I. Among these lessons were the need for a more adequate Medical Corps with greater authority in sanitary matters, the value of trained female nurses to the



Fig. 8. — Army ambulance, Tampa, 1898 (Courtesy of the Florida State Archives).

Army, and the importance of compulsory typhoid vaccine innoculation. The Army Nurse Corps began as part of the Army Medical Corps in February 1901. Antityphoid vaccination began on a voluntary basis early in 1909 and became compulsory in March 1911. However by far the greatest lesson learned was the importance of adequate camp sanitation.

Acknowledgments

The author would like to acknowledge the assistance of the following persons: Mrs. Betty Bruce, Jim Clark of the Calder Memorial Medical Library, Mrs. M.H.E. Casey, Mrs. Mary C. Gillett, Wright Langley, Sister M. Rose Adelaide Morin of the Sisters of the Holy Names, Gary R. Mormino, Executive Director of the Florida Historical Society, Michael Musick of the National Archives, and Scheffel H. Wright, M.D.

References

1. Izlar, R.P.: Inaugural Address, Trans. Florida M. A., April 19-20, 1899, pp. 23-29.
2. Sternberg, G.M.: Sanitary Lessions of the War, JAMA 32:1287-1294 (June 10) 1899.
3. Wright, S.H.: Medicine in Florida Camps During the Spanish-American War. Great Controversies, J. Florida M. A. 62:19-26, 1975.
4. Keuchel, E.F.: Chemicals and Meat: Embalmed Beef Scandal of Spanish-American War, Bull. Hist. Med. 48:249-264 (Summer) 1974.
5. Report of the Commission Appointed by President to Investigate Conduct of War Department in War With Spain. 8 Vol, Washington, Government Printing Office, 1899. Hereinafter referred to as the Dodge Commission. Testimony of Colonel Wiley Jones, p. 353.
6. Schellings, W.J.: Soldiers in Miami, 1898, Tequesta #17: pp. 69-76, 1957.
7. Reed, W.; Vaughan, V.C., and Shakespeare, E.O.: Report on Origin Spread of Typhoid Fever in United States Military Camps During Spanish War of 1898, Two Volumes, Washington, Government Printing Office, 1904. Hereinafter referred to as the Reed Commission, Vol. 1. p. 492.
8. Reed Commission: Vol. 1, p. 490.
9. Reed Commission: Vol. I, pp. 573-574
10. Nolan, E.M.: One of the Causes of An Epidemic of Typhoid Fever in Military Camps. Special Reference to Camp Cuba Libre, Letter to the Editor, Medical Record 54:499-500, (Oct. 1) 1898.
11. Raymond, H.I.: Medical Organization of Camp at Tampa, Florida, Medical News, New York, 72:590-591 (May 7) 1898.
12. Ashburn, P.M.: History of the Medical Department of the United States Army, New York, Houghton Mifflin Company, 1929, p. 208.
13. Dodge Commission: Testimony of Major Daniel M. Appel, p. 2874.
14. Dodge Commission: Testimony of Mrs. Joseph John Gest, p. 1349.
15. Dodge Commission: Testimony of Dr. Lawrence D. Knowles, pp. 1701-1702.
16. Martin, R.A.: A Century of Service, St. Luke's Hospital, 1873-1973, privately printed, 1973, pp. 119-120.
17. Dodge Commission: Testimony of Mrs. Joseph John Gest, p. 1352.
18. Bigelow, Poultney: "In Camp at Tampa," Harper Weekly Magazine, XLII:550, June 4, 1898.
19. Reed Commission: Vol. I, p. 501.
20. Vaughan, V.C.: Conclusions Reached After Study of Typhoid Fever Among American Soldiers in 1898, JAMA 34:1451-1459 (June 9) 1900.
21. Dodge Commission: Testimony of Dr. Lawrence D. Knowles, pp. 1703-1704.
22. Vaughan, V.C.: Conclusions Reached After Study of Typhoid Fever Among American Soldiers in 1898, JAMA 34:1459 (June 9) 1900.
23. Reed Commission: Vol. 1, p. 507.
24. Reed Commission: Vol. 1, p. 484.
25. Martin, R.A.: A Century of Service, St. Luke's Hospital, 1873-1973, privately printed, 1973, p. 123, footnote 77.

- Dr. Straight, 555 Biltmore Way, Suite 201, Coral Gables 33134.

Hookworm eradication program of Florida in the early 20th century

H. Frank Farmer Jr., M.D., Ph.D.



At the turn of the 20th century, a popular conception existed throughout the United States that the average Southerner was mentally deficient, lazy, and lacking in initiative. This stereotype was a composite of many characteristics. It was the Georgia redneck, Florida cracker, and Tennessee hillbilly all rolled into one. When these were combined into the "average" Southerner, those outside the region had no trouble envisioning a skinny, gaunt-face farmer, shackled by misery and poverty. With his wool hat, faded blue denims, and wad of tobacco, the Southerner made himself a place in the folklore of the nation. He was pictured as a person whose mental processes were slow, with an intelligent quotient far below that of the average American. Without doubt the picture was distorted but it prevailed for many years and gained wide acceptance. The Southerner himself accepted the bleak picture. He was chronically weak and never appeared to have the energy to exert himself. His children were stunted and lacked alertness and vigor. The high death rate was a part of life. It seemed hopeless to try to fight whatever caused the condition as the South was crucified on a cross of misery, ignorance and laziness.

Many causes were considered such as inadequate diet, improper clothing, and climate. All of these caused some of the deficiencies, but few suspected that the main culprit was an intestinal parasite — the hookworm. This half inch worm was literally sucking the South to death. The hookworm was first discovered in America in the 19th century and even though it was a known infectious parasite little was known about the process by which it infected its victims. Some newspaper editors and doctors in the very early 1900s pointed to the possibility of the worm being the cause of the "lazy disease" but were laughed at in the South. It was an insult to suggest that its people had worms. The idea was repulsive and seemed to strike at Southern manhood and pride. As a consequence, the region resisted any type of investigative procedure.

The man who broke this veil of secrecy and definitely proved that the hookworm was a large part of the South's physical ills was Charles W. Stiles, M.D., a native North Carolinian working in Washington as a zoologist with the Bureau of Animal Industry. Dr. Stiles, a pioneer in the early detection of hookworm disease, was publicly pointing to the hookworm as the scourge of the South as early as 1891. Hookworm had been known in Europe for many years before American physicians were able to prove that it existed in the United States. There is evidence that American doctors knew hookworm was present in the United States as early as 1845 but the first proof came in 1893 from Abe Blickhalm, M.D. He treated a case of hookworm in an immigrant German brick-

H. FRANK FARMER JR., M.D., PH.D.
Dr. Farmer has a Ph.D. in history and is a former professor of history. He practices general internal medicine in New Smyrna Beach.

layer and published a paper on his findings in *The Philadelphia Medical News.* Other reports soon followed in Richmond and New Orleans; however, these were still isolated cases and did not generate much attention among American medical men. It was not until 1901 that the right case fell into the hands of the right men, Allen J. Smith, M.D., of Galveston, Texas. Dr. Smith treated a seaman at a Galveston hospital who was suffering from anemia and weakness. He noted that the seaman had spent time on a Mexican plantation prior to entering the United States. Since Dr. Smith had visited Mexico and knew the symptoms of hookworms, he immediately looked for the disease and found the worms. An account of the case, and the treatment, was published by M. Schaeffer, M.D., in *The Texas Medical News.*[1]

Neither of these men received credit for the discovery of a new species of hookworm even though Dr. Smith felt that the worms he examined in Galveston were not of the *Ancylostoma duodenale* or European variety but of a distinctly different species. However, he did not get a chance to examine any more patient's with the parasites for some time. Meanwhile, a doctor on the east coast, Charles W. Stiles, also suspected that hookworm was widespread in the United States. Dr. Stiles was not a medical doctor but a zoologist.[2] In his studies of animals he often found hookworms in the intestines of the weak and anemic ones. Noting that the symptoms of the animals were often the same as those of European victims, Dr. Stiles wondered if the "lazy" Southerner might not also be the victim of hookworm. He lacked definite proof but the logic was inescapable. The European hookworm could live in either host, man or animal. The incidence of hookworms found in animals from the Southern region was always high.[3] It seemed reasonable to assume that the Southern population was heavily infected. Dr. Stiles reached this conclusion in the early 1890s and expanded on the theme in later years. Throughout the 1890s he was hampered by lack of evidence with which to work. He lacked specimens and could only pursue his idea through lectures and articles. Fortunately, he influenced many medical students. In 1896 he delivered a series of talks on tropical parasites at Georgetown University in which he advised students if they ever went south through the tropics and found a case of anemia of which the cause is not clear, the should look for hookworms. One of the students, Baily Ashford, later joined the Army and was stationed in Puerto Rico as a medical officer treating the native population. He noticed a great number of cases of unexplained anemia. Remembering the advice of Dr. Stiles, he took fecal specimens of the patients and found hookworms. Noticing that these were not the old world variety of Ancylostoma duodenale, he sent specimens to Dr. Stiles for further study. It was at this time that Dr. Smith was working on the hookworm in Galveston and both he and Dr. Stiles were in correspondence. Dr. Smith had sent specimens from Texas and with the ones from Puerto Rico Dr. Stiles had enough from which to work.

Both Drs. Smith and Stiles prepared papers but Dr. Stiles won the race and on May 10, 1902 he read a paper before the Pan-American Sanitary Congress in which he described the new species of hookworm and named it *Necator americanus* or the American murderer.[4] Dr. Smith was still working on his paper and thus missed the opportunity for a medical first. Dr. Stiles thought he had discovered a new species of parasites but it was soon shown that the American hookworm was from Africa, probably brought by Negro slaves.

Dr. Stiles claimed that he had found the "germ of laziness" and asked the South to join with him to help eradicate it. He knew there were elements in the region who would back any program to improve the area. Walter Hines Page had already demonstrated his desire to campaign against any and all Southern ills. The fiery North Carolinian had been taking the South to task in his paper, *The State Chronicle,* since the early 1880s. The hookworm idea was just the sort of thing that interested him. There were others, native Southerners and outsiders, who were inclined to see the whole thing as a joke such as Irwin Cobb of *The New York Evening World.* The morning after Dr. Stiles made his announcement at the Pan-American Sanitary Congress, *The World* noted that the "germ of laziness" had been discovered. Most of the press of the country made it the joke of the season.

Southerners were shocked by the claim that hookworm was widespread in the region. They felt that sweet potatoes, sorghum molasses, turnip greens, catfish, and sow belly were treatment enough for the worst case of laziness. Spokesmen shouted the defense of Southern health and vitality. If the hookworm could live through all the bad corn whiskey that Southerners drink, nothing could kill it, said facetious commentators. In most cases it was rather difficult to explain away the theories of Dr. Stiles. The medical profession in the South was the one group that adhered almost unanimously to Dr. Stiles' theory as it began to turn up overwhelming evidence that hookworm was definitely present.[5]

In 1909, the Rockefeller Foundation entered the fight against the hookworm. Directors were impressed with the efforts of Drs. Stiles, Page, and others. They were convinced that a well planned, concentrated program of eradication could reduce the ravages of the worm and on October 26, 1909 the Sanitary Commission for the Extermination of Hookworm Disease was organized for a period of five years with an endowment of $1 million.[6] When the Commission entered the fight, it had little precedent with which to work. On January 8, 1910 it opened its doors in the Union Building in Washington, D.C., immediately responded

to appeals from the South and moved into the region to begin work. With its entry eradication of hookworm disease took on a well endowed and well planned campaign which would include education and upgrading of sanitary standards and facilities.

Florida's program • Florida was the only southern state not included in the initial Rockefeller campaign. The state had already set up a hookworm eradication program and served largely as a model for the other states and for the Rockefeller Commission. The only precedent for a mass attack on hookworm had been carried out in Puerto Rico under auspices of the American Army and in the state of Florida under local health authorities. In 1904 the legislature of Puerto Rico appropriated $5 thousand and appointed Drs. Baily Ashford and Juan Guiteras to head the campaign. They were so successful that the appropriation was later renewed and increased. This initial venture served as a model in many ways for the work that was done in the South. By 1910 physicians in Florida were knowledgeable on the subject of hookworm disease, had adequate financing and were starting to develop a comprehensive public health program. In 1909 the annual budget for public health services was $75,000. The money was raised by special tax of half a mill for maintenance of the State Board of Health.[7] This compared with $16,000 for Alabama, none for Arkansas, $21,000 for Georgia, $5,000 for Kentucky, $25,000 for Louisiana, $48,000 for Texas and $40,000 for Virginia. Florida was also ahead of the other state in that the rules and regulations of the State Board of Health had the force of law which gave it a lever for enforcing decisions concerning privies and other sanitation measures. Texas and Virginia were the only other public health systems which had this authority. Florida was the only State Board in the South which exercised full authority over local health organizations. Three well equipped laboratories operated in Jacksonville, Pensacola and Tampa.[8] Furthermore, the Board of Health issued *Florida Health Notes*, a monthly publication. It was written in laymen's language and was designed to give the residents of the state information on public health matters. It was sent free charge to anyone who requested it.

Even before the formal announcement by Dr. Stiles in 1903 of the presence of the worm in the United States, the South had already been warned that hookworm was a serious threat. In 1902 Dr. H.P. Harris of Atlanta called it a danger to the population. His report preceded by ten days publication of Bulletin Number 10 of the United States Hygenic Laboratory entitled *A Report Upon the Prevalence And Geographic Distribution of Hookworm Disease In The United States* written by Dr. Stiles.[9] The following year, physicians in Tampa began to observe the disease and reported their findings to Dr. Hiram Byrd, Assistant State Health Officer. Dr. Byrd immediately took steps to survey and determine the extent of the disease. The work of eradication in Florida dates from that year. The physicians of the state quickly took steps to acquaint themselves with the disease and in June 1903 the first medical paper on hookworm in the state was read before The Jefferson County Medical Society by A. R. Conter, M.D.[10]

From 1903 to 1908 the State Board of Health disseminated information to physicians and the general population but took no other positive action. The aggressive phase of the campaign began in December 1908 when Board members attended the Florida State Teachers' Association and pointed to the large number of children afflicted with the disease. Dr. Byrd gave the report and said of 285,000 school age children in Florida over 200,000 lived in rural and small communities under conditions conducive to development of hookworm disease. He did not show the exact extent of the disease because no complete survey had been undertaken. The history of the disease as well as its nature and treatment were discussed and Dr. Byrd ended with a plea to the teachers that they learn about the disease and report any suspected cases. The report was well received and the State Superintendent of Public Instruction requested that every teacher be furnished with a copy and placed on the mailing list of *Florida Health Notes*.

The State Board of Health inaugurated a system of subsidized payment to physicians for those patients who could not otherwise afford hookworm treatment. The program went into effect in June 1909. The only condition of payment was that diagnosis had to be confirmed by one of the state laboratories and a complete report filed with the Board. This seemed more feasible than any other plan since it was free from the stigma of charity. The State Board of Health was supported by direct taxation and the people felt they were getting a service for which they had already paid. The Board of Health also made available to the public a kit from which specimens could be submitted to the state laboratories for examination. These were furnished without charge and consisted of the case, a bottle of liquid preservative in which the fecal specimens were placed, and a blank form to be completed. While the Board of Health dealt with individuals in this instance, it advised self treatment must be avoided and the patient must report to his doctor.[11] Information on the construction of sanitary privies was also disseminated through the state.

Field service • While the 1,000 doctors in Florida pursued their fight against hookworm with vigor, the state was simply too large for them to reach every individual. To combat this deficiency two physicians were placed in field service to contact the mass of sufferers who would otherwise not have been informed.

E. W. Diggett, M.D., began this work in Lee County, one of the worst infected areas in the state. The field program began in October 1909 and included a complete survey of the state with contact as far as possible of every potential patient. Dr. Diggett visited schools, teachers, ministers and families. Significantly he brought all matters of public health to the attention of the people and did not confine his work to hookworm disease alone even though that was the main emphasis of the program. C. T. Young, M.D., the other field officer, began his tour in December 1909. Both of these men were responsible for disseminating to the citizens of Florida how hookworm was transmitted, how it could be avoided, how the diagnosis could be made and the treatment that was available.

Seventeen days after Dr. Diggett was authorized to begin field work, the Rockefeller Foundation announced its gift of $1 million for eradication of hookworm in the South. Physicians and health officials of Florida were elated because the public could now be reached in greater number and doctors would have better lines of communication.

On January 19, 1910 a conference on hookworm disease was held in Atlanta. The purpose was to bring together physicians throughout the South to discuss measures of eradication.[12] Joseph Y. Porter, M.D., State Health Officer, and Hiram Byrd, M.D., represented the Florida State Board of Health. They were disappointed in the conference because nothing new was added to their knowledge. They felt that any physician who was reasonably informed about this disease already knew what was covered. However, they failed to understand that many of the other doctors were totally ignorant about the disease and its treatment. Drs. Porter and Byrd went to the conference to hear the report of the North Carolina Board of Health which had done a great deal of education work, but the program did not include this report.

Through 1910 Florida's program of eradication was led by Drs. Porter, Byrd, Diggett and Young. Dr. Young had covered Osceola and Orange Counties and was enroute to Manatee County by the beginning of March. Dr. Diggett concentrated on the Georgia-Florida border in Jefferson and Leon Counties. Dr. Byrd traveled throughout the state at large giving lectures and demonstrations. Thus, by the end of March, Lee, Desoto, Polk, Osceola, and Orange Counties had been systematically covered.[12]

Program efficiency • The Rockefeller Sanitary Commission recognized the efficiency of Florida's program by sending other doctors to observe operations. Wickliffe Rose, Executive Secretary of the Rockefeller Foundation, was responsible for sending A. G. Fort, M.D., of Lumpkin, Georgia, to Florida. Dr. Fort was later appointed Assistant Secretary to the State Board of Health of Georgia. Dr. John Ferrell, who was in charge of the hookworm program in North Carolina, also visited the state. The Florida State Board of Health issued a three month report for the period in June 30, 1910 and made the report available to Rose and the Sanitary Commission. The report showed the work had slowed down in the spring due to an outbreak of smallpox around the Florida, Georgia and Alabama lines. However, it did not hinder the program significantly. The report also showed that the most intensive work was carried on in the southern part of the state where six counties had been covered. Fifteen to 20 counties in the northern and western part of the state had work done in them but had not been covered in their entirety. During the quarter another assistant to the State Health Officer was added. Laboratory examinations were increasing at the rate of about 10% a month. Over 2,000 examinations had been conducted in the central laboratory in Jacksonville during the quarter including 750 in May alone. The Tampa laboratory was constructed in March and it was estimated that over 2,000 examinations would be made there before the end of 1910. Arrangements for the opening of a branch laboratory in Pensacola was completed in June. Equipment was ordered and a bacteriologist from the State Board of Health was assigned to the laboratory. The report estimated that the laboratory would handle over 12,000 examinations annually. The central laboratory in Jacksonville kept a record of the counties which sent in specimens. Of the 47 counties in the state, 42 used the services of the laboratory. Of the remaining five counties, two had extensive work performed by private physicians who conducted their own examinations. One of these, Bradford County, had been a center of hookworm activity since 1904. The other two counties were squeezed between hookworm invested counties in such a way that the extent of their infection was fairly well known.

The State Board estimated that 75% of all victims were cured with two doses of thymol. There were two methods of administering the medication which differed somewhat from that previously used. One was to give thymol in small capsules with an equal amount of milk and sugar; the other was to give the medication at night instead of in the morning. The changes were introduced by E. W. Warren, M.D., of Palatka in 1907 and had been thoroughly tested by him. They were incorporated as permanent recommendations of the State Board of Health and were consequently recommended as standard procedure by the Rockefeller Sanitary Commission.[14]

The importance of lectures and publications was stressed. Folders were prepared for the public that were written and illustrated in the simplest terms and could be left in any country store to be picked up. A more detailed paper was prepared for the teachers of the state. It was comprehensive enough to serve as a guide in the hookworm work though it was written

in simple language. Lectures were given at institutions of higher learning such as the Florida State College for Women, West Florida Normal School, and Florida Agricultural and Mechanical College, and before professional groups such as the Florida State Press Association and the North Carolina State Medical Association in Wrightsville Beach. All these tactics made an impression on the Rockefeller Sanitary Commission and were later incorporated into their program. The Commission also continued to send observers to Florida. In late 1910, Olin West, M.D., of Tennessee and J. B. Ward, M.D., of South Carolina visited the state under auspicies of the Rockefeller Foundation.

Through 1911 hookworm work continued, although 2,700 fewer examinations were conducted than in 1910, the efforts having been hampered by smallpox epidemics. The State Board of Health estimated that all physicians of the state were thoroughly familiar with the disease and parents and teachers always suspected the hookworm if a child was sick. The number of cases treated at state expense increased by 25% over the proceeding year. During 1912 dispensaries were established along railroad lines and in the areas of heaviest infection in the western part of the state to compensate for the delay in sending specimens to the state laboratory. Drs. Diggett and Young were in charge of the dispensaries which the Rockefeller Sanitation Commission later used as models for other states.

To the credit of the Florida State Board of Health, minority ethnic groups were not left out of the public health program. The Seminole Indians who resided in the swampy areas of south Florida were sought out and treated. In July 1913 W. J. Godden, M.D., a medical missionary to the Seminoles, wrote the State Board of Health and requested that physicians be sent to the Seminoles to investigate hookworm disease. The Board sent Dr. Diggett to the Everglades for the purpose. Out of approximately 100 children examined, only one was negative.[15] It was noted that the Indians showed very few physical signs of hookworm disease. After 1913 the Board of Health regularly sent physicians to the Seminoles to treat hookworm and other diseases.

Because of the leadership role Florida took in its hookworm eradication program, the citizens of the state were among the best treated and most educated about the disease. As a result of the hookworm program and the efforts that went into educational and eradication phases, the Florida State Board of Health received a firm foundation. There were, of course, other factors involved in its development such as yellow fever epidemics but the concentrated efforts over several years in the hookworm program laid the basis for the organization and later was used in many areas involving public health. Hookworm was not eradicated but its incidence greatly reduced and the people of Florida had a better quality of life because of the efforts of the early pioneers of public health.

References

1. Schaeffer did not directly participate in the experiments but wrote the findings at Smith's request. Carter, Marion Hamilton: The Vampire of the South, McClure's Magazine 18:617-631, 1909.
2. Clark, Thomas: The Emerging South, Oxford University press, pp. 2S-26, 1901.
3. Hagman, R.L.: Hookworm in the South; Its Diagnosis and Treatment, Railway Surgical Journal 29:46-47, 1912.
4. Stiels, C. W.: History and Zoologic Aspect of Hookworm Disease, JAMA S4:390-392, 1910.
5. Smith, C.A.: Uncinariasis in the South with Special Reference to Mode of Infection, JAMA 43:S92-S97, 1904.
6. Rockefeller Commission: The Rockefeller Sanitary Commission for the Eradication of Hookworm Disease: Organization, Activities, and Results up to December 31, 1910, Office of the Commission, Washington, D.C., pp. 2-4, 1910.
7. Rockefeller Commission: State Systems of Public Health, Office of the Commission, Washington, D.C., pp. 14-18, 1910.
8. Florida State Board of Health: Twenty-Second Annual Report, for 1910, State Board of Health, Jacksonville, pp. 29-30, 1911.
9. Stiles, C. W.: Prevalence and Geographic Distribution of Hookworm Disease, U.S. Public Health Service, No. 10, Government Printing Office, Washington, D.C., p. 3, 1903.
10. Florida State Board of Health: Twenty-First Annual Report, for 1909, State Board of Health, Jacksonville, p. 21, 1910.
11. Florida State Board of Health: Hookworms, Florida Health Notes 4:82, 1909.
12. Florida State Board of Health: The Conference for Eradication of the Hookworm Disease, Florida Health Notes S:25, 1910.
13. Florida State Board of Health: Hookworm Campaigning in Florida, Florida Health Notes S:77, 1910.
14. Rockefeller Foundation: Annual Report, 191S, Rockefeller Foundation, Washington, D.C., pp. 212-214, 1916.
15. Florida State Board of Health: Twenty-Fifth Annual Report, for 1913, State Board of Health, Jacksonville, p. 127, 1914.

● Dr. Farmer, 405 Downing Street, New Smyrna Beach 32069.

History of Tuberculosis in Florida

L.C. Manni, M.D.



The history of tuberculosis and that of medicine run parallel courses. Tuberculosis was mentioned in the earliest known medical writings. In 1882 a German, Robert Koch, isolated the tubercle bacillus and identified it as the specific germ that caused tuberculosis. A handful of sanatoria offered treatment of a sort for the unfortunate tuberculosis patient, and there were few individuals, including some physicians, who thought the germ could be stopped or its devastation stayed. In the United States at the turn of the century the situation was generally considered hopeless. To most people tuberculosis was a hereditary disease, a disgrace, an inescapable curse that ran in families. There was a hopelessness about tuberculosis, a fatalism born of fear and ignorance.

Dr. Joseph C. Placek Sr., of Cleveland, Ohio, a pioneer in the treatment of tuberculosis, wrote prior to 1900, "The standard treatment was an airtight room, with the patient wrapped up in a featherbed and stretched out behind a red-hot stove. It was a question at times whether he died of tuberculosis or parboiling." Large doses of creosote and whiskey were the commonest medication but some doctors began to doubt the efficacy of this treatment when they heard rumors of patients overtaken by spontaneous combustion. Old wives remedies, said Dr. Placek, "were generally based on the premise that the bacilli had a sense of smell; they included sleeping on manure piles, eating dog fat, a regular diet of garlic, and sleeping in a room with one or more savory goats." Stoves and featherbeds became antiquated when the fresh air rage captured the public imagination about 1900.

Florida became health conscious in 1889 when during a special session of the legislature the State Board of Health was created. The State Board of Health Act was designed primarily to fight yellow fever but was enlarged with the passing years as it was soon discovered that tuberculosis was the major public health problem. Around 1900, and for many years thereafter, no one knew how much of a health problem consumption, pulmonary tuberculosis, really was in Florida. Dr. Joseph Y. Porter, Key West, Florida's health officer (1889-1917) admitted he did not. A few years later Dr. Porter regretted special reports of the disease were not compulsory but reported more information was obtainable since the opening of the state laboratories at Jacksonville in 1903. An early estimate of the tuberculosis deaths is shown in Dr. Porter's report of 1903 in which he said, "Consumption seems to have claimed 742 victims during the past year." (The death rate was approximately 145.0 per 100,000 population as compared with 9.8 in 1953).

When the state laboratory was established, tuberculosis posed an apparently insurmountable health problem that frustrated the best efforts of the public

The Author
L.C. MANNI, M.D.
Dr. Manni was the Medical Director in 1948 of the TB Hospital at Marianna and, although semi-retired, works part-time at the Leon County Health Department.

health officers who were inclined to attribute the "white plague" to the " damyankees" who brought it here from the north.

An early effort and failure were recorded in 1903 when the Florida Medical Association sought to interest the legislature in isolation facilities, which Dr. Porter stated, "would, in our opinion, prevent the danger of infection." The anti-TB crusaders believed some form of quarantine would help control the spread of TB. Dr. Porter proposed to the legislature that the state establish "shack shelters" or "tent towns" in the pine barrens, distant enough from centers of population so consumptives could not mingle with the residents. "Hospital buildings are not needed," he told the legislature, "the sufferers need to live outdoors and drink in nature's curative power." Similar recommendations to successive legislatures failed.

Isolation hospitals ● The State Board of Health built isolation hospitals in Duval and Dade Counties and in the cities of Pensacola and Tampa. Boarding homes began providing for tuberculosis patients under a variety of conditions. The Sunshine Sanatorium was a private enterprise established by Dr. J. E. Ennis from Illinois. He settled near Narcoosee in Osceola County and was suffering from tuberculosis when he came to Florida but recovered after a few years. He fixed up a place near his home where persons with tuberculosis could come and camp and, through *Everybody's Magazine*, invited the afflicted to come and bring their tents. Their only expense would be for groceries. Mrs. Ennis later agreed to feed the patients at cost. During the winter of 1904-05 he had 15 patients, all of whom, it was reported, improved. In 1907 Dr. Ennis offered the Sunshine Sanatorium property to the state without cost, the only condition being the state should appropriate $10,000 a year to demonstrate whether or not open air treatment was practical. The legislature refused the gift.

A hospital for 30 patients was built in Gainesville and opened in 1893 by the Odd Fellows Lodge. It was used for Lodge members with tuberculosis until 1914 then converted to a home for the aged. A camp for military men with tuberculosis was established in 1903 but it operated less than three years. The facilities were offered to the Board of Health but the modest funds needed were not made available by the legislature.

The 1909 legislature authorized the State Board of Health to acquire and maintain a sanatorium for the treatment of the indigent tuberculous. The Board had $60,000 available but without warning the legislature transferred the funds to pay confederate pensions. At this period there was no institution in Florida, state, county or private, where the indigent consumptive could receive care and treatment unless he was insane, feeble-minded or a criminal. There are some records of early sanatoria, one being the naval hospital at Pensacola where an open air TB camp was maintained. In 1907 Dr. R. L. Harris of Orlando operated a small sanitorium on the outdoor plan and reported "Camp Cohasset" was proving satisfactory.

In 1913, influenced by his failure to secure legislative support for a TB sanatorium, Dr. Porter reported a new approach to the TB menace. He stated, "A sanatorium is not the most satisfactory solution of this problem." He planned to bring TB treatment to the homes of the patients through the employment of public health nurses or "tuberculosis instructors" as he chose to call them. The program started in 1914 with three "tuberculosis instructors." This was the start of a very vital part of tuberculosis control in the state.

Several agencies were active in the fight against tuberculosis and in 1916 the Florida Anti-Tuberculosis Association (now the Florida Lung Association) joined the other agencies. The Association supported the 1917 Florida Tuberculosis Hospital bill that authorized counties to build and operate TB hospitals. Under the 1917 legislation Duval County Anti-Tuberculosis Association, the first to be organized in the state (1909), campaigned vigorously for a Duval County TB hospital. In a special election the bond issue carried and 2-mill tax was voted. The bonds were sold and construction started. The 1923 legislature repealed the Tuberculosis Hospital Act of 1917 but the hospital which was nearly completed became the property of the Duval County Welfare Board.

Several counties throughout the state attempted to operate small sanatoria. Hillsborough County's original sanatorium was a frame building first used as a stockade and then for a short period was a home for a small number of veterans of World War I with tuberculosis. In 1921 four wards were built of screen and fitted with canvas awnings.

During the 20s and 30s many of the county health departments used the "Burr Cottages" for isolation of their patients. These cottages were named after Dr. Burr who recognized the importance of isolation and fresh air. These cottages were small one-room buildings that could be transported to the patient's back yard. A nurse from the health department instructed the patient regarding food, disposal of excrements, etc.

In the 1920s with increased strength and numbers, the antituberculosis forces campaigned for TB sanatoria without which TB control was thought impossible. There was no pill, no potion, no way to immunize against tuberculosis. Sanatoria isolated patients and thus began to break the chain of person to person infection.

State sanatoria program ● In 1927 the legislature passed the Florida State Sanatorium Act establishing

a state-supported TB sanatoria program to be administered by a commission or board, members to be appointed by the governor. A Board was not appointed until 1934 and the state TB sanatoria program was activated. The original members on the Board were J. Maxey Dell, M.D., of Gainesville, Mrs. Murray L. Stanley of Daytona Beach, and W. T. Edwards of Jacksonville who was appointed chairman and remained in that capacity until 1957 when he resigned and A. G. Holley was appointed to replace him. The Board began planning sanatoria construction without funds and in 1937 when Florida's share of the Dupont Estate taxes wree about to be paid into the state treasury, Edward Ball, executor, Mr. Adair, attorney for the Dupont Estate, and Mr. Edwards requested the Cabinet to set aside the $200,000 appropriated by the 1927 legislature for the sanatoria program. This was approved and $160,000 was set aside to match federal funds. The cornerstone for the state's first TB institution was laid November 3, 1937 in Orlando. The building was dedicated January 3, 1938 and the first patient was admitted February 1, 1938.

Control efforts ● Before the opening of the Orlando sanatorium, collaspe therapy (pneumothorax and pneumoperitoneum) was being used in some of the county sanatoria and in private clinics. In 1930 a concerted effort to control tuberculosis was made by the State Board of Health. In 1930 11 diagnostic clinics were established and staffed and were functioning. In 1932 a full-time clinician and a nurse were employed and four years later a Division of Tuberculosis was formed. Tuberculin skin testing was first started in 1932. The first x-ray unit was obtained in 1936. It consisted of a unit that could be dismantled and moved from clinic to clinic. Exposures were made on rolls of paper film which had to be sent to New York for processing. In 1937 six pneumothorax clinics were in operation throughout the state. In 1940 the first mobile x-ray unit was obtained. After World War II six modern mobile photofluorographic units were put into service and by 1957 over 500,000 persons a year were being x-rayed. At that time the average yield was one case of tuberculosis per 1,000 x-rays. Later the percentage dropped and x-rays were aimed at high incidence areas.

In 1939, a year after the first hospital was opened in Orlando, casefinding in the indigent and migrant groups was stressed. The first community wide x-ray program sponsored by the State Health Department was staged at Port St. Joe in 1944. The x-ray unit was borrowed from the U.S. Public Health Service. In the 50s chest x-rays were taken of all admissions to general hospitals, and jail inmates.

A survey of Florida's sanatorium needs was made in 1944 by Henry D. Chadwick, M.D., of Massachusetts and a recommendation for five sanatorium districts was made. In an effort to relieve the critical tuberculosis situation (the Orlando hospital was filled to capacity and there was a long waiting list) the Board acquired facilities at Drew Field, Tampa, and at the Marianna Army Air Base from the War Assets Administration. The Northwest Florida TB Hospital, 250 beds, was opened at Marianna November 11, 1946 and the Southwest Florida TB Hospital, 500 beds, was opened at Drew Field January 20, 1947.

W. T. Sowder, M.D. became State Health Officer in 1945 and C. M. Sharp, M.D. was appointed Director, Bureau of Tuberculosis Control, in 1946. This marked an acceleration in the tuberculosis program with an increase in mass x-ray surveys and establishment of the central case register.

Through the combined efforts of the Tuberculosis Board, State Board of Health and Florida Tuberculosis and Health Association the legislature released funds in 1948 for construction of the 500-bed hospital at Lantana. In 1949 the legislature earmarked $6,000,000 for tuberculosis sanatoria from the cigarette tax collected outside cities. These funds were used to finance construction of the new 508-bed institution at Tampa and a new 400-bed hospital at Tallahassee. The Tampa hospital was dedicated March 28, 1952 and patients admitted May 6, 1952. The W. T. Edwards Hospital, Tallahassee, was dedicated April 6, 1952 and patients admitted May 26, 1952. Since the opening of the Orlando hospital in 1938, nearly 14,000 patients had been admitted to the four hospitals as of March, 1954. All four hospitals had a surgical suite and staff. All types of thoracic surgery were performed and over 50% of the patients received some type of collapse therapy before the use of antibiotics. The state tuberculosis hospitals employed the most advanced methods, techniques and procedures, making full use of drugs, surgery, and laboratory research.

By 1959 it was apparent that the fifth hospital was not needed and there was a surplus of beds in the four hospitals. The Orlando hospital was phased out in January 1960 and the W. T. Edwards Hospital in Tallahassee in January 1967. The Tuberculosis Board was abolished in 1969 and the hospital program was combined with the community program in the Bureau of Tuberculosis Control. The Tampa hospital was closed in September 1974 leaving the Lantana hospital the only one in the state. The census has gradually decreased and is presently below 100.

Shifting emphasis ● In the late 30s emphasis was placed on casefinding. Tuberculin skin testing was done in high schools with follow-up chest x-rays of the positive reactors.

The opening of the Orlando hospital was a big step forward but was unable to meet the needs of the state. Admissions were made on a basis of those most likely to benefit from hospital care. The far advanced cases were not admitted. Even after the opening of the barracks hospitals in Marianna and Tampa there was

a waiting list of 3,541 active cases in 1950. The death rate dropped from 71 per 100,000 in 1930 to 50 per 100,000 in 1940.

During the 40s casefinding continued and emphasis was placed on adult groups. Education of the public was emphasized, industries were surveyed. Additional mobile x-ray units were ordered in 1945. The temporary hospital facilities were opened in Marianna and Tampa. Streptomycin became available in the hospitals. This drug was expensive and scarce at first and it was soon realized that a second drug had to be added to prevent the development of resistant organisms. Paraminosalicylic acid was soon used in combination with streptomycin and the development of resistance prevented. The death rate continued to drop and was 19 per 100,000 in 1950.

During the 50s the three new tuberculosis hospitals were opened, one at Lantana, at Tampa to replace the barracks hospital, at Tallahassee to replace the Marianna air base hospital making a total of close to 1,800 beds. Isoniazid became available and the hospitals at Orlando and Lantana joined the Public Health Service in a carefully controlled study in the use of the available drugs; namely streptomycin, paraaminosalicylic acid and isoniazid. Later all four hospitals were involved in research with the Public Health Service to determine the best combination.

Antibiotics became available for outpatient therapy so that patients could be discharged sooner from the hospital and the length of stay shortened. Two mobile x-ray units were added so that casefinding could be accelerated and high incidence areas pinpointed. Tuberculin skin testing was increased in 1959. The death rate in 1960 was 2 per 100,000.

The treatment of tuberculosis changed markedly during the 60s with more new antibiotics being added and the hospital length of stay decreased. At one time the average length of stay was 18 to 24 months and in 1969 it was five months. The treatment concept changed, from state hospital based to community based.

Federal grants were available for special projects and Florida received proportionately more funds than any other state in the nation. New mobile x-ray equipment was obtained to lessen radiation hazard. A study to determine the reliability of the Tine skin test compared to the Mantoux was made and the Mantoux test found to be more reliable. Special projects in eight counties using federal grant monies were carried out. The federal projects were phased out in 1969.

In 1966 chemoprophylaxis programs were initiated. Preventive therapy using isoniazid 300 mg daily for 12 months was given to positive tuberculin reactors to prevent the development of active tuberculosis. Priority was given to household contacts, children and young persons, people with x-ray evidence of previous infection (scars on lungs) and those with diseases known to be associated with a high incidence of tuberculosis.

In 1966 the W. T. Edwards Hospital in Tallahassee was closed, and the average length of stay for patients had decreased to 143 days in 1969. After the Tuberculosis Board was abolished the remaining two tuberculosis hospitals were placed under the Division of Health.

The death rate in 1969 was less than 2 per 100,000 and the case rate dropped from 26.5 to 24.7 although the number of new cases reported in 1969 was 1,572 and the number in 1959 was 1,271. This drop in case rate was due to the increase in population in the state. The increase in number of new cases was due to Cuban refugees, migrant workers and new cases from other states.

Continual gain ● The 70s showed continual gain in the fight against tuberculosis. A new drug (rifampin) was added to the ten others. Two drugs in combination with others showed remarkable promise in the cure of tuberculosis. Shorter regimens of treatment were studied and proved successful. Outpatient treatment programs were developed making it possible to treat most patients outside the hospital or after a very short stay in the hospital. In 1973 35% of newly diagnosed cases received total care at home. A cooperative patient at home taking his medicine presented no hazard to his community. Tuberculosis seminars in cooperation with the Florida Lung Association, its local chapters and county health department nurses and health officers, tuberculosis associations personnel, and students from colleges and universities involved in health training were held throughout the state. These seminars were aimed at making persons involved in tuberculosis care aware of the new trend in treatment. As much as 95% efficiency in follow-up of patients as outpatients was obtained in 1970.

Due to the success of home treatment and shortened hospital stay the hospital census continued to drop and the hospital at Tampa was closed in 1974. There was further cut back in use of the 70 mm mobile x-ray units. Due to the increased load in the outpatient clinics a request for 40 additional personnel consisting of physicians, nurses, laboratory technicians, field workers, and clerks was granted but before these positions could be filled the funds were removed from the budget.

The number of new cases reported in the 70s remained fairly consistent. In 1975 there were 1,758 new cases reported with a case rate of 21 per 100,000. In 1980 there were 1,647 new cases reported with a case rate of 16.9 per 100,000. The treatment trend was to return tuberculosis to the mainstream of medicine. General hospitals throughout the state were solicited to care for patients when necessary but most were reluctant. Today the state has contracts with four general hospitals for the care of tuberculosis patients:

University Medical Center, Inc., Tampa General Hospital, Tallahassee Memorial Regional Medical Center, and Public Health Trust of Dade County (Jackson Memorial Hospital).

In 1979 the death rate in Florida for tuberculosis was 1.6 per 100,000. Up to 1984 there has been a gradual decrease in reported new cases (1,335) for a case rate of 12.3 per 100,000. When the State Board of Health was established the annual death rate for tuberculosis was 200 or more per 100,000 and in 1982 the rate was 1.1 per 100,000. The average age at the time of death in 1917 was the late teens or early 20s; 60 years later the average age is over 60 years. Today patients can be diagnosed in the early stages and treated at home with little or no restrictions. Drug treatment has revolutionized treatment and recovery is expected if patients cooperate. Surgery which was a major part of treatment at one time has dropped to less than 1% of treated patients.

In spite of all the success attained in control of tuberculosis it still remains a major public health problem and eradication is probably a long way off.

The story of tuberculosis control, although not over, is the result of a combined and cooperative effort of several organizations and their leaders, many of whom have not received full recognition for their diligent work in helping to control a major cause of mortality in the state.

● Dr. Manni, Route 2, Box 528, Tallahassee 32301.

Mosquito control — its impact on the growth and development of Florida

John Andrew Mulrennan Jr., Ph.D.



In 1845, when the Statehood of Florida was being debated in the Congress, the Honorable John Randolph of Virginia rose to declare that Florida could never be developed, nor would it ever be a fit place to live. He described it as "A land of swamps, of quagmires of frogs and alligators and mosquitoes." This was a perfect description at the time when the population was 66,500, the greatest percentage of which was living the northern part of the state from Pensacola to Jacksonville.

Human existence for many during those days was bare survival due to the ravage of parasites and diseases that plagued the people on a year-round basis. The most horrifying of the diseases was yellow fever which swept through the towns and villages in the summer months affecting literally hundreds of people.

The Author
JOHN ANDREW MULRENNAN JR., PH.D.
Dr. Mulrennan is Director, Office of Entomology, Department of Health and Rehabilitative Services, Jacksonville.

Great pestilence • The year 1857 is remembered as a time of great pestilence. It was reported that approximately 600 persons in Jacksonville had yellow fever and that 127 died.

In 1877, 1,612 out of a population of 3,000 in Fernandina were sick with fevers. Ninety-five people died including Dr. Francis Preston Wellford, president of the Florida Medical Association. Dr. Wellford had volunteered to aid the sick and dying and left Jacksonville for Fernandina on September 22. Seventeen days later, he died of yellow fever.

In 1887, yellow fever epidemics occurred in Key West, Tampa, Plant City and Manatee. In 1888 the disease broke out in Jacksonville causing an exodus from the city of people in carriages, drays and wagons streaming toward the depot and docks while every outgoing train and steamer was crowded beyond capacity. In all nearly 5,000 had contracted the disease and more than 400 had died. The epidemic finally subsided on November 25 when the temperature dropped to 32 degrees.

For a period of 141 years epidemics can be chronicled throughout the state with six major pandemics culminating in the great pandemic of 1888. During the 141 years well over 25,000 cases were recorded with more than 5,000 deaths.

It was the pandemic of 1888 that provided the final impetus for establishing the State Board of Health and naming of Dr. Joseph Y. Porter as the first state health officer. Earlier attempts had always failed, eg, in 1873 a bill which carried a $200 appropriation was introduced in the legislature to organize a State Board of Health but was defeated on the basis of being too expensive.

Dr. John P. Wall in an 1875 address to the Florida Medical Association stated: "The time is fast hastening when preservation of the public health will

become one of primary consideration in all enlightened governments." This statement laid the groundwork for the advancement of public health. Dr. Wall is often called the father of the State Board of Health as a result of his early efforts. He was a man far ahead of his time because in 1873 he postulated that the common "treetop" mosquito was the carrier of yellow fever 27 years before Walter Reed proved it.

Malaria belt • While the occurrence of yellow fever epidemics were visibly dramatic and devastating, the occurrence of malaria and dengue was far more subtle but, over the years, equally as devastating.

The early settlements of Florida were almost entirely within the area later defined as the "malaria belt." Tallahassee, the state capitol, was in the midst of this region. Malaria persisted well into the 20th century affecting thousands of Floridians. This disease along with dengue and yellow fever caused retardation of Florida's growth and unestimatable economic damage.

In 1898 Sir Ronald Ross proved the role of the *Anopheles* mosquito in transmitting malaria and in 1900 Walter Reed verified the mosquito theories of Wall and Findlay relating to yellow fever. These discoveries marked the beginning of the end of the three major mosquito-borne diseases in Florida. The last case of yellow fever occurred in 1910, dengue in 1932, and malaria in 1948.

The discovery of the mosquito's role in disease transmission lead to the beginning of mosquito control programs in Florida. Major emphasis was placed on elimination of breeding sources. The elimination of cisterns for drinking water, rain barrels, and other receptacles eliminated the vector and yellow fever.

Control efforts • Malaria control efforts were first organized during World War I when the U.S. Army, U.S. Public Health Service, and State Board of Health set up a program of drainage and larviciding at Camp Johnson near Jacksonville. In 1919 the state, city of Perry and Burton-Swartz Cypress Company jointly set up a malaria control project in Perry, one of the state's most highly malarious areas.

All the early mosquito control efforts in Florida were aimed at disease control but as early as 1922, when the Florida Anti-Mosquito Association was formed, the importance of pestiferous mosquito control was becoming apparent. Enabling legislation for creation of mosquito control districts was passed in 1925 and in the next ten years five districts were formed. Their main efforts were directed toward the salt marsh mosquito.

In the ensuing years, local, state, and federal agencies, and private foundations such as the Rockefeller Foundation combined research and control efforts to bring about elimination of malaria and dengue and reduction on a grand scale of the pestiferous salt marsh mosquitoes.

Most people will agree that it has been the control of mosquitoes and mosquito-borne diseases that has allowed Florida to expand its agriculture, increase tourism from a winter business to year-round and provide a mecca for millions of people to work and play. Florida is now one of the fastest growing states in the nation.

New problems • While the economic benefits of Florida's growth is enormous, it presents new problems in public health and mosquito borne-disease control. Florida has changed since the turn of the century from an essentially rural state with small villages and towns to large urban and suburban areas. These areas are often situated in or near large mosquito breeding areas or, by their construction, have created new ones.

St. Louis encephalitis (SLE), an urban/suburban vector-borne disease, now poses a threat to our population. Epidemics occurred in the Tampa Bay area in 1959 (68 cases, five deaths); 1961 (25 cases, seven deaths); and 1962 (222 cases, 43 deaths). In 1977 another epidemic occurred involving 23 counties in central and south Florida with 110 cases and eight deaths. Isolated human SLE cases have occurred occasionally since then and in recent years the virus has been routinely isolated from sentinel chicken flocks primarily in south Florida.

Eastern equine encephalitis (EEE) also occurs sporadically in humans and equines and human cases are usually associated with campers, hunters or fishermen who have frequented fresh water swamps which have a history of endemic EEE.

It seems now that there is an irony associated with our mosquito and vector-borne disease control programs. We have successfully eliminated yellow fever, malaria, and dengue and greatly reduced pestiferous mosquitoes. This has allowed Florida's population to grow. The growth that has occurred has created new man-made mosquito habitats conducive to vector mosquito breeding or has placed human populations in close proximity to endemic EEE areas. These situations pose potentially serious public health problems in Florida's future.

History often repeats itself. We can only hope that this is not the case for mosquito-borne diseases in Florida. Florida's history of these disease is too terribly devastating to be repeated.

• Dr. Mulrennan, Department of HRS, P. O. Box 210, Jacksonville 32231.

The best of both worlds: general practice in rural Florida, 1928-1950

David P. Adams



The community of Orange is located in north central Florida. Isolated by a 20 mile drive to the urban center to the north and 25 miles to its southern urban neighbor, the hamlet of approximately 500 persons presently has no full-time medical care. Except for two days each week when a dentist and family physician practice there, residents must travel at least a half hour for either medical or dental care. A pharmacist is the only resident health care provider.

Yet James H. Kirby, M.D., offered Orange residents personal, competent medical attention for nearly 50 years. As one study suggeted, his motives were probably based on his own rural background.[1] Furthermore, the physician's aversion to any form of socialized medicine reflected contemporary trends in medicine as well as his deep sense of patriotism. His practice combined a genuine concern for the health of his patients with a desire to maintain whenever possible the profession's growing orientation toward scientific medicine and professional solidarity. Within the first 20 years, Dr. Kirby established a hospital-based, characteristically "urban" practice in an otherwise rural environment.[2]

Early years of practice • James H. Kirby (Georgia Medical College, 1927) completed his internship at the Duval County Hospital, Jacksonville, Florida, in the late spring of 1928; he entered general practice in Orange in late summer of that year. The young physician arrived following the death of Dr. A. C. Auslander. The need for a replacement came unexectedly for Dr. Auslander died suddenly after "taking a blood poisoning in his hand." On June 16, 1928 he succumbed quickly; death came at the closest available hospital — 25 miles south of Orange.[3]

Dr. Kirby learned of Orange's need for a physician shortly after Dr. Auslander's death; by September he had settled into the community and had taken over the deceased physician's practice. Dr. Kirby did not intend to remain in Orange, wishing to stay only until a permanent replacement could be found. A member of the Loudermilk County Medical Society, of which Dr. Kirby was a member, insisted that the booming practice in Orange provided enormous incentive to remain. The large practice lured him from his plan to specialize in plastic surgery.[4]

Dr. Kirby decided to settle in Orange; several years later he had married and started a family. The early years of his practice, the deepest of the Depression decade, did not discourage him. During these years he endeared himself most deeply to residents. Dr. Kirby's habit of spending the night at the bedside of an ailing patient appears to have had a profound im-

The Author
DAVID P. ADAMS
Mr. Adams is a Ph.D. candidate in the History Department and serves as a resource faculty in the Medical Humanities Program of the Department of Community Health and Family Medicine, University of Florida.

pact upon their preceptions of proper medical care. According to one woman whose child he delivered in 1929, Dr. Kirby displayed deeply empathetic concern. In her case, the child was born when "everyone had the flu — and it killed you." The night she gave birth, gravely ill, Kirby stayed "right there." Several years later when her young daughter lay sick with diphtheria, Dr. Kirby stayed by the bedside through the night. Even so, she insisted, "you paid him when you got it." Unlike today, she lamented, the doctor "would come to see you if you was [sic] sick."[5]

Dr. Kirby's patients appear to have had the greatest faith in his abilities, but some relied on folk remedies during the difficult Depression years. One patient stated, "You kind of doctored yourself." Although this patient bore six children in Orange, Dr. Kirby only saw one during a childhood illness. She added, "[You] didn't have no doctor for mumps, whooping cough." This was especially true during the 1930s. "It was rough," she remembered simply. For malaria, she recalled, Orange residents dosed themselves with "666" and "Grove's Chill Tonic" — sometimes in addition to Kirby's quinine prescriptions. During the summer, "everyone had it [malaria]."[6]

The malaria problem reached its peak during the mid-1930s. Poor drainage of low-flying agricultural areas and stifling heat on summer evenings combined for high malaria morbidity rates. To exacerbate this problem, one resident recalled, "Half the people didn't have screens on the house," adding, "mosquitoes'll eat you up." Some residents had screens on their windows but many often spent humid evenings on front porches. Sitting in the relative comfort of the veranda, Dr. Kirby's patients made choice snacks for early evening insect feedings.[7]

While Dr. Kirby's medical training was excellent by standards of that day, he lacked specialization but one of his colleagues remembered "He did everything and he did it well." Dr. Kirby practiced skillfully but it is quite likely that his generalist training left him with perplexing situations. One of his colleagues recalled an experience in the early 1930s — an unexpected emergency on a small child. He performed the procedure on a kitchen table and later recalled, "I did it on thirty thousand cats before it did it on a baby."[8]

Pneumonia could prove equally trying. Prior to the advent of antibiotics, Dr. Kirby typically gave patients "as much food as they could take" and glucose. "We had nothing to stop the bacteria," one physician noted sadly. Still, Dr. Kirby's training was better than many of his colleagues, especially when compared to those trained at proprietary medical colleges. At these schools, a colleague noted, teachers "couldn't be teaching much medicine if they didn't know anything."[9]

County medical society activities ● When Dr. Kirby began practice in 1928, he soon became an active member of the Loudermilk County Medical Society. By early 1929 his membership dues ran $12 per year: $10 for the Society and $2 for the Florida Medical Association. It is unclear what (if any) malpractice insurance he carried; however, such coverage seems insignificant by modern standards. As of August 15, 1929, Dr. Kirby (if he had accepted the United States Fidelty and Guaranty Company's offer) would have paid an average of approximately $13 per year in premiums. "X-ray for treatment," the USFG letter explained, "costs double the amounts quoted; for diagnosis only — at no extra charge."[10]

Dr. Kirby, despite his rural isolation, made every effort to cultivate professional contacts through active participation in his local medical society, headquartered 25 miles south. Although he arrived in the county in late summer of 1928, Dr. Kirby does not appear on the attendance rolls until December 17, 1929. The medical society minutes are missing from August 1931 until December 1938; however, available records suggest that Dr. Kirby regularly attended meetings. These helped to keep him and his colleagues well informed through continuing education programs. In June 1931, for example, the Society corresponded with the Metz Laboratories "concerning motion pictures" on various clinical topics. A month later the Society voted to screen them before the Central Florida Medical Society meeting scheduled for October. The LCMS presented the films in conjunction with a "sponsored educational program at a local theater."[11]

The general economic problems of the 1930s did not often intrude on concerns of the LCMS. The Society embodied a blend of progressive and traditional thinking. For example, the question of a local birth control clinic arose in December 1938 but the Society did "not consider it best to have anything to do with such a preoposed [sic] clinic." Dr. Kirby, installed as vice president that month, probably supported this opinion; a sample of 370 of his prescriptions written during the 1930s and 1940s shows no contraceptives and only a few drugs for dysmenorrhea. His prescription files indicate that he prescribed other drugs (sedatives, analgesics, expectorants, etc.) with the same frequency as an urban practitioner.[12]

Dr. Kirby showed considerable concern for science in the educational curriculum. At the February 1939 meeting he related his efforts to lobby for a "Basic Science Law." To help the bill along, the LCMS moved that $50 "be sent to proper authorities for aid in passage of the law." The following month Dr. Kirby announced plans to give a talk at a regional medical meeting in October 1939. Shortly after the LCMS motioned that a telegram be sent to appropriate representatives "requesting their support of the Basic Sciences Bill."[13]

The surviving records of the Society reflect little worry over either national or local economic problems. While private discussions may have taken place

in backrooms and hallways, the official record shows no concern over the general effect of the Depression or international tensions during the decade. Even when the invasion of Poland drew Europe into war in September 1939, socialized medicine represented a far more grave menace. Of particular worry was the question of the Society "having oversight" over a nearby county "in medical matters." Dr. Kirby strongly backed this concern and brought it to the attention of the LCMS: Should the LCMS cooperate with New Deal health care programs under the Farm Security Administration (FSA)? At the October 1940 meeting, the group proudly filed "a letter from Mr. Wilkie, Republican nominee for president, relating his views on socialized medicine. . .by unanimous vote of the club."[14]

The relationship between FSA "clients" and socialized medicine provided lively discussion at LCMS meetings . At one gathering, one of Dr. Kirby's fellows "rose and stated that the Medical Society had sold out to socialized medicine." Dr. Kirby himself led a decision that the Society could refuse treatment to those individuals "who are judged able to pay the usual fees." The LCMS approved this motion on November 21, 1940. The concern by Dr. Kirby in particular over "many outstanding accounts against the F.S.A." resulted in the March 1942 decision "that no more sexual intercourse [sic] be permitted between the Farm Security [Administration] and the [Loudermilk County Medical Society]." Given the rather blunt wording of the motion, it "was slightly altered to read: The [Loudermilk County Medical Society] will discontinue participation [sic] in the Farm Security Administration setup, as it is Socialized Medicine in the crudest form." To be effective April 16, 1942, Dr. Kirby seconded the motion and it passed unanimously. Concern over the FSA precluded all formal discussion of America's entrance into World War II; even Pearl Harbor and the subsequent loss of the Philippines escaped the official notice of the LCMS. Finally at the June 18, 1942 meeting "various discussions regarding war took place."[15]

Once the LCMS rid itself of the FSA threat, the wartime patriotism of its members took over. In August 1942 the Society invested "funds on hand in War Bonds" and purchased a $500 note; a month later one physician suggested that the body assume dues "for members in the Armed Service." The patriotic spirit did not include eager participation in the Emergency Maternity and Infant Care Plan (EMIC), and the Society initially turned down involvement. According to a letter from Dr. Lucille Marsh of the Florida State Board of Health, LCMS' physicians would receive only $50 per patient to cover complete maternity care for "the wives of our enlisted men in the lower pay grades."[16]

At the next LCMS meeting, discussion of the EMIC plan appeared again. The program was linked to socialized medicine, and intense opposition arose from the floor. As one member advised, "It establishes a precedent for further extension of governmental intrusion into the private practice of medicine." The LCMS concluded that EMIC patients should only be accepted on an individual basis — and only in the interest of the soldiers. The LCMS grudgingly called EMIC "military welfare." Dr. Kirby, opposed to socialized medicine but intensely patriotic all the same, probably shared the sentiments of the LCMS. On at least one occasion he attempted to enlist in the armed forces but was refused due to his crucial role as the sole health care provider in northern Loudermilk County.[17]

EMIC did not provide the final threat to the LCMS. Shortly after the proposal of the Wagner-Murray-Dingell Bill, a plan designed "to bring about a system of 'cradle to grave' social insurance," the Society decided to face its "menacing provisions" head-on. In March 1944, the LCMS concluded, "It would be necessary for doctors in future to take more interest in politics, and we should have paid representatives (lobbyists) at Tallahassee and in Washington, D.C. to follow current legislation." Later that year, in its own mass lobbying campaign, the AMA contacted the Society. The purpose? To keep local physicians "informed regarding the present day threat of socialization of medicine through some form of compulsory health insurance."[18]

Bastion of modern medical practice • Throughout the 1930s and 1940s Dr. Kirby was active in the LCMS and concurred with its decidely fee-for-service orientation. In the late 1940s, he brought another bastion of modern medical practice to his community: in 1947 Orange gained a hospital, "Kirby's Hospital," as it was called. Prior to its opening, patients requiring hospitalization travelled 25 miles to the nearest fully-equipped health care center. Shortly before his 20th year of practice, Dr. Kirby opened the private facility which he owned and operated: "A complete, modern hospital, equipped to handle all emergencies." The AMA had officially recognized it by the fall of 1948.[19]

Dr. Kirby originally intended the complex for maternity patients but it soon became a "full-fledged hospital with a staff. . .and set up as a 25-bed institution." C. R. Parker, M.D., a 1945 graduate of the Medical College of Georgia, assisted Dr. Kirby; three "consulting nurses," three nurses, two cooks, hospital director , "collaborating pharmacist," two "housemaids," laundress, "caretaker," and Dr. Kirby's wife as the "chief dietician" provided the complement. In short, Dr. Kirby's personnel reflected that of a basic modern hospital staff. The facility even boasted a "completely equipped laundry — at a cost of $700."[20]

In addition to three private rooms, the complex had "one medical ward, a surgical ward, and obstetrical ward, with eight bassinets in the glass-

enclosed nursery." Complying with segregation laws, the structure had a "colored annex" with both "male and female wards." For emergencies "the hospital boasts an emergency treatment room, a spotless, well-lighted operating room, scrub room, sterilizing and supply room, the staff dining room, and a modern kitchen." Although the hospital had "a laboratory equipped for all routine laboratory work, and physiotherapy," it also had the use of x-ray and laboratory facilities at nearby hospitals in which Dr. Kirby enjoyed privileges. According to a contemporary description, he "equipped his hospital with [the] best equipment possible."[21]

Dr. Kirby located the facility in a late Victorian home, completely refurbishing the interior; modern flourescent lighting provided illumination "throughout the hospital." "Thermostatically-controlled air-conditioning and heating" created a comfortable health care environment. Dr. Kirby's participation in Blue Cross of Florida by February 1947 probably encouraged a steady stream of patients. During one week in November 1948, he admitted five: one from as far away as Elmode, Georgia; he discharged three, one from Orlando.[22]

The cost of a stay in the hospital seems almost unreal by modern standards. One woman, whose child Dr. Kirby delivered in May 1947, received an itemized bill. Six days in the hospital totalled $147: $48 for the room, $75 to cover the delivery of her child, $4 for medications, $10 for care of the child, and $10 for miscellaneous fees.[23]

Professional solidarity • By 1950 Orange boasted a well-equipped hospital and a competent physician whose practice reflected both his urban training and rural social background. While he practiced in an area removed from the medical mainstream, Dr. Kirby's activities in local and regional medical societies suggest an attempt to counteract the isolation so common in rural medical practice. Further, "urbanized" prescribing practices and a successful hospital may well reflect both his medical school and internship experiences. Of all sole health care providers in Loudermilk County during the 1930s, Dr. Kirby alone received his training at an AMA accredited institution. Upon graduation, the AMA-approved Duval County Hospital provided — by standards of the day — exposure to high-tech scientific medicine.[24]

One pressing question remains with regard to James Kirby's medical practice: why, when his patients suggest that he never insisted upon payment, did he worry so greatly over outstanding accounts with the FSA and its relation to "socialized medicine?" Dr. Kirby's training came during a period of increasing power on the part of the medical profession and his AMA-accredited medical school probably stressed the necessity of professional solidarity. Moreover, Dr. Kirby's family and friends suggest that he was a deeply patriotic individual. Economic considerations aside, he may have associated legislation such as the Wagner-Murray-Dingell Bill with an affront to the American Way and, far worse, a harbinger of the Red Menace. His patriotism proved so intense that during the war years he often prescribed B-vitamins, widely publicized as "morale boosters." His prescription files show them as second only to sedatives in frequency of appearance.[25]

Dr. Kirby never practiced outside of Orange and its surrounding rural community; for nearly 50 years he provided residents with capable and personal health care. During the first 20 years, his relative youth and excellent training (other rural community health care providers in the county averaged 60 years of age and had graduated from proprietary medical colleges) helped to establish a high standard of medical care. His death in 1974 ended abruptly an anomaly in rural Florida medicine.[26]

Perhaps the predicted growth of the number of physicians will entice future graduates to take up practice in the area. One recent study of rural health care observed all too correctly, "As the older physicians die or retire, another rural community is left without the services of a doctor." Save for intermittent visits by a dentist and family practitioner, Orange may long remain in this unfortunate category.[27]

Acknowledgments

I would like to thank Dr. Mark Barrow for his assistance in locating materials upon which this study is based and Dr. Lee A. Crandall, and Ms. Murray Laurie for their helpful comments on the manuscript.

References

1. James H. Kirby, M.D., Orange, Florida and Loudermilk County Medical Society are pseudonyms for an actual physician, community, and county medical society as are the names of all residents of "Orange." Their true identities have been ommitted at the request of family members and residents of the community upon which this study is based. "Rural" is defined as communities with less than 1,000 persons. See especially, Richard C. Reynolds, Sam A. Banks, and Alice M. Murphree, eds., The Health of a Rural County (Gainesville, 1976), 60-68. For discussion of the rise of scientific medicine in America, see William Rothstein, American Physicians in the 19th Century: From Sects to Science (Baltimore, 1972); see also Rosemary Stevens, American Medicine and the Public Interest (New Haven, 1972).
2. Personal interview, Dr. Dieter Ross, December 13, 1984, herinafter cited as Ross, personal interview.
3. Personal interview, Mrs. Venita Jackson, December 13, 1984, herinafter cited as Jackson, personal interview.
4. Jackson, personal interview; Ross, personal interview; personal interview, Mrs. Fronita Kirby, December 11, 1984.
5. Personal interview, Mrs. S.W. Andrews, December 13, 1984, hereinafter cited as Andrews, personal interview.
6. Jackson, personal interview.
7. Personal interview, Mr. Eugene Vining, December 13, 1984, herinafter cited as Vining, personal interview.
8. Ross, personal interview.
9. Ibid.
10. United States Fidelty and Guaranty Company to Loudermilk County Medical Society, August 15, 1929, Minutes of the Loudermilk County Medical Society, hereinafter cited as Minutes. These documents are in the personal files of Karl Altenburger, M.D., Ocala, Fl.
11. Minutes, June 18, 1931, and July 16, 1931.

12. Minutes, December 15, 1938; The sample upon which these conclusions are based are in the personal files of David P. Adams, University of Florida, Department of History. For a quantitative breakdown of urban prescribing practices, see especially Frank Delgado, The Professional Pharmacy: An Analysis of Prescription Department Activities, 2d ed. (Washington, D.C., 1935), 130 ff.
13. Minutes, February 16, 1939, March 16, 1939, and May 18, 1939.
14. Minutes, November 16, 1939 and October 17, 1940.
15. Minutes, October 17, 1940, November 21, 1940, March 19, 1942, and June 18, 1942.
16. Minutes, August 21, 1942; Lucille Marsh to F.D. Frank, November 2, 1943.
17. Minutes, November 12, 1943 and December 16, 1943.
18. Minutes, February 16, 1944; June 15, 1944; Paul Starr, *The Social Transformation of American Medicine* (New York, 1982), 280.
19. "[Orange] Hospital Equipped to Handle All Emergencies," *Gainesville Sun*, November 21, 1948, 3; Starr, *The Social Transformation of American Medicine*, 145-179.
20. Ibid.
21. Ibid.
22. Ibid.
23. Itemized statement in the personal files of Mrs. A.W. Jackson, Orange, Florida. The author wishes to thank Mrs. Jackson for calling this bill to his attention.
24. See especially, David P. Adams, "General Practice in Rural Florida: Case Study of an Anomaly," J. Florida M. A. 72:517-521, (July) 1985.
25. Starr, *The Social Transformation of American Medicine*, 280-289. Geoffrey Perrett, *Days of Sadness, Years of Triumph: The American Home Front, 1939-1945*, (New York, 1973), 331.
26. Adams, "General Practice in Rural Florida," 520.
27. Reynolds, Banks and Murphree, eds., *The Health of Rural County: Perspectives and Problems*, 68.

● Mr. Adams, University of Florida, Department of History, 4131 GPA, Gainesville 32611.

Who killed Cock Robin?

Robert D. May, M.D.



Each person considers an historical event biased by his or her ancestry, upbringing, cultural values, social ambience, and professional tradition and training. A lawyer, therefore, would be influenced to some extent by developments of the law at the particular time, the politicians by lasting accomplishments of those most influential in government, and the physicians by significance of the event as related to the health and well being of future generations.

Consider Francis P. Fleming, inaugurated governor of Florida January 8, 1889, age 47 years three months, and the special single-issue session of the legislature he caused to be convened the following month.

Fleming was born at Panama in Duval County on September 28, 1841, son of Col. Lewis Fleming, an honored gentleman and gallant soldier in the Indian Wars who inherited from his father Capt. George Fleming, large tracts of land originally granted by the Spanish government in recognition of distinguished services in behalf of Florida during the Spanish dominion. Before he was 20 years of age Fleming entered the military service of the Confederate states as a private in Capt. John W. Starke's company of volunteers. He served with honor in the Army of Northern Virginia as a member of the regiment (Second Florida Infantry) in which his elder brother, Capt. Charles Seton Fleming, was a distinguished officer. In August 1863 Fleming was appointed first lieutenant in the First Florida Calvary, serving in the Army of Tennessee. In this capacity he took part in the campaigns of Generals Johnson and Hood. Entering the study of law on his return to Florida, he was admitted to the bar in 1868 and made his home at Jacksonville where he became a member of the prominent law firm of his elder brother, Louis I. Fleming, and Col. James J. Daniel in 1873. Both of these distinguished men lost their lives in the yellow fever epidemic of 1888.

Postwar politics • Fleming, as a young returning C.S.A. veteran, had been so distraught over the South's loss of the Civil War that he had anguished over leaving the country and settling in Brazil. Instead he turned his attention to rebuilding the abandoned family plantation at Hibernia which he found overgrown with weeds and brush and until recently occupied by deserters from the Federal Army.

In 1866 Florida was under a tight government of military occupation and most officials at all levels were appointed rather than elected. They were carefully selected from the Republican Party and from the huge influx of carpetbaggers following establishment of the Freedmen's Bureau in Florida (1865-1867). The Democratic Party, still smarting from the 1865 suicide of its Civil War leader, Governor John Milton,

The Author
ROBERT D. MAY, M.D.
Dr. May is a third generation Florida physician who has practiced general medicine, pediatrics and public health both outside and inside the State of Florida over the last 34 years. In addition to being interested in medical management strategies for good public health in Pasco County, Dr. May also has a deep and abiding interest in Florida history and the history of medicine.

struggled to survive in Reconstruction Florida. To get back in the good graces of a vengeful federal Congress required a revision of the state constitution. A revision was attempted in 1865 and elected members, most of them slave owners (my great-grandfather, Asa May, was a representative from Jefferson County), did everything the Congress wanted except indemnify their former slaves for "damages." The Congress, however, would not readmit Florida to the Union; military rule and occupation continued.

Another constitutional revision commission was appointed in 1868 by Republican Governor David S. Walker. In addition to repeating the clarion call for establishment of a centralized State Board of Health (which must have really stuck in the craw of many long-time southern democratic political leaders of the day), it repeated the work of the 1865 convention, despite its being called the Carpetbagger Convention. It also called for establishment of a public school system which may be why local control of public education by district school boards is such a vital issue in this state to this day.

Meanwhile, the Democratic Party was pulling itself together and Francis Fleming was an integral part of this rebuilding in post-Civil War Reconstruction Florida.

From the time he was admitted to the bar Fleming had been active in politics, participating in almost every campaign, including the memorable one of 1876 which terminated the Reconstruction period of eight and a half years by election of Governor George F. Drew. Fleming was an excellent speaker, serving for a number of years as a member of the State Democratic Executive Committee as well as participating in nearly all state-level political campaigns.

The 1877 inauguration of Governor Drew, for whom Fleming had campaigned tirelessly, coincided with withdrawal of federal troops from the south and signalled a new era in Florida politics. Fleming was typical of the state's rising democratic leadership. This group, often referred to as the "Bourbons," included many Confederate veterans. They shared a sentimental attachment of the "Lost Cause," advocated a strong policy of white supremacy, and hoped to rebuild Florida's economy by attracting northern capital to the state.

In the 1880s, wartime memories were still important political realities. Fleming nominated his friend, General Perry, for Governor of Florida at the State Democratic Convention in Pensacola and his fiery speech reportedly brought rebel yells from the gallery. Strong support for Perry, which resulted in his selection as the Democratic Candidate and subsequent election, was due in part to his illustrious war record. The close political bonds between the veterans of the Second Florida is further illustrated by Perry's selection of Colonel David Lang as State Adjutant General in 1885. Lange served until 1893.

Governor Perry's administration saw the deepening division of the once solid Democratic Party into an agricultural reform faction which championed the cause of the small farmer, demanded stringent regulation of the railroads and challenged the "Bourbon" party regulars. When the state Democratic Convention met in St. Augustine in May 1888 to choose a candidate to succeed Perry, Fleming was one of the three nominees, each a party regular with strong local and personal followings. He received the nomination on the 40th ballot.

Economic problems • Fleming was inaugurated as Florida's 15th Governor in January 1889. The following month, he summoned a special session of the legislature for the purpose of establishing a State Board of Health over the loud and vociferous objections of many of his political friends and advisors! It followed the most severe and extensive yellow fever epidemic during the summer and fall of 1888.

The threat to the Florida economy by actions of local boards of health and the inability to control these boards must have been a primary consideration of Governor Fleming. It is most probable that economic factors had considerable weight in his decision.

The Carpetbagger Constitutional Convention of 1868, invading railroad barons, economic disaster under the Confederacy and reconstruction had resulted in economic growth staggering along a slow route toward recovery. This enveloped the state and the new governor in a gloomy cloud of pessimism.

State finances were in poor shape. Governor Fleming began his administration hampered by a considerable deficiency in general revenue. This was due to the large increase in annual expenditures which had practically doubled since 1884 in response to the demands for increased responsibilities and functions of the government under the new Carpetbagger Constitution. Nearly $40,000 a year was being appropriated for state seminaries, agricultural college, normal schools, teachers' institutes, and deaf, dumb and blind asylum; $40,000 more was required by the Railroad Commission and pensions to veterans, and $60,000 annually for criminal prosecutions which had been expenses borne by the counties prior to 1884.

One of the first signs of hope for the economy was an influx of northern tourists, particularly into the St. Johns River Valley. Margaret Fleming, like other impoverished but enterprising plantation owners, converted her home into a boarding house and resort for the new visitors. Favorable descriptions of Hibernia appeared in a number of travel books and tourist guides which became popular in the late 1860s and 1870s. Thus, the Flemings were enterprisingly able to make ends meet.

Did the local county boards of health quarantining of ports, the railroads, and the "shot gun"

county quarantine of the roads against other counties for citizens and visitors, on foot, horseback and in carriages stimulate tourist and potential settlers interest?

Yellow fever outbreaks each summer were a direct threat to the economy of Florida which was becoming more and more enamored of and dependent on tourists, new settlers, and developing railroads in the 1880s.

Tourism and its growth as a marketable industry with the increase of more adequate transportation would bring rapid expansion of the state's development. Fleming's vision of Florida's meaningful future way back in 1888 was right on target. He bet on his knowledge, experience and skills regarding politicians and in the art and science of the political process. He gambled on the State Board of Health issue as a single issue so as to avoid jeopardizing his other intended political issues and programs. His gamble was a masterful political stroke.

Medical developments • Twenty years after the end of reconstruction, what was the historical development of medicine in Florida? What were the medical forces which came to bear on Governor Fleming's call for a special session to establish a state board of health?

Medical organizations were a minor and ofttimes insignificant force from the early days up to and including the late 19th century. There was paucity of physicians. As near as can be estimated in its earliest colonial days, Florida as a territory of Spain and of England acknowledges only two, Henry Woodward, M.D. and Andrew Turnbull, M.D. who seem to have been the only doctors prior to American rule connected with important events not related to their profession. Doctors were always few in Florida during the colonial period. There were more during the British period than any other, but more than half of them were in the service of the Army.

From the earliest days, Florida was touted as a healthful place. Many people moved to Florida to escape the rigors of a hurtful climate or to strengthen their struggles against a crippling disease. Consider the following excerpt from the "Story of Florida" by Cash:

> Shortly after 1830 there moved to Florida a young Pennsylvania physician suffering from lung trouble and hoping that the climate would cure it. Not only was his health restored, but he lived to be an old man. This gentleman, Edward Bradford, M.D., not only built up a fine reputation as a physician, but throughout his life was considered one of the leading citizens of Leon County.

And again from a report of Surgeon General Lawson published just after the Civil War:

> The general healthfulness of Florida, particularly on its coast, is proverbial. The average annual mortality of the whole peninsula from returns in this office is . . .2.06% (20.6 per thousand); while in the other divisions of the United States it is 3.05% (30.5 per thousand). . .it may be asserted without fear of contradiction that Florida possesses a much more healthy, agreeable and salubrious climate than any other state or territory in the union.

What physician, who earned his bread and board taking care of the ill, would feel his skills were needed and would be compensated in a land of health such as Florida was reputed to be? Small wonder that out of a total state population of 140,424 in 1860, there were only an estimated physician population of 200 or about 0.1% of the total population.

Licensing of physicians in Florida has been a complex issue since early days. Prior to 1821 there was no licensing at all. In 1821 one of the first ordinances of the new territorial governor, Andrew Jackson, was to establish a Board of Health with the power of port quarantine for Pensacola and a Board to regulate medical practice. What the composition of this board was and how effective it was is unknown.

An act of 1828 provided for a medical board whose function was to hold an examination once a year for the convenience of prospective physicians and the protection of the public. The members of the board were all doctors. It is interesting to note that the act was repealed in 1831.

The state of licensing in 1831 continued along the lines of an apprentice/guild member tradition: licensing of the apprentice compliments of his guild-member peers. Physicians were in small numbers, often of varied educational qualifications and training.

Florida physicians formed professional groups slowly and tenuously. Because of a number of factors there was little if any professional grouping until late in the 19th century. Medical societies began in the counties with the most populous cities and preceded the state society's founding on January 14, 1874 by many years. The state society was in all probability not a particularly potent force in the 1880s, some six years later.

In Escambia County there were 12 local physicians present at the first society meeting in 1873. In Duval County six physicians attended the first meeting in 1853, 21 years before the founding of the Florida Medical Association. Proceedings of the Association in January 1889, 15 years after its founding, list 36 dues-paying members, according to Treasurer J.D. Fernandez, M.D. Dues that year were $5.00.

Organized medicine cannot be considered much of a force, if any, in producing the legislation of 1889 which resulted in establishment of the State Board of Health. Nor is it probable, given the historical evidence available, that individual physician prestige, wealth, and/or educational backgrounds were primarily forceful factors throughout the young state in this landmark legislation.

What influence there was on Governor Fleming was achieved by contact with back-home doctors like R. P. Daniel, Able Baldwin, Mitchel, Murdock and many others. These physicians participated in the life of the community by serving with other prominent citizens on church vestrys, boards for CSA veterans' widows and children pensions and benefits, boards of directors of banks, libraries, health and sanitary committees, civic organizations and groups such as Mason and Elks. It was during the social intercourse that friendly physician guidance and advice to Governor Fleming and other political leaders was most valuable and effective.

Conclusion • "Who killed Cock Robin?" was the rhetorical question with which we began our search into the facts surrounding the historical event of the special legislative session in February of 1889 which established a centralized state Board of Health and called for the establishment of local Boards of Health as needed for Florida.

We considered the event from various historical perspectives; to wit, a lawyer/politician named Francis P. Fleming, a social scientist of the times, an economist of the period, and the physicians of the gilded era.

The sum of political, economic, social, and medical factors to varying degrees, and in that order, probably led to the legislation of 1889 which created the State Board of Health in Florida and granted it broad powers of quarantine for uniform disease control.

The most important factor in the mind of Governor Fleming and his Democratic political colleagues was certainly in part to demonstrate to all other Florida politicians and to the citizens at large that southern Democrats were firmly in charge of state government and that they intended to govern during Fleming's term in a most highly principled and responsible civic manner. Although the "Bourbons" were unreconstructed rebels and conservative white supremists, they were forward thinking progressives in terms of big business (especially the developing railroads) and understood the need for improving Florida's economy by increasing tourist trade and speeding up development. These economic factors were of tremendous importance in establishment of a centralized State Board of Health to control epidemic disease and local boards of health as needed during a specially called session of 15 working days in February 1889. Governor Fleming's primary goal must have been to protect and improve the economic conditions of the state.

Social factors, while less important, certainly must have had some influence. Interference with the political process of nomination, campaigning, and election in the face of an unstable population in the port cities (where most of Florida citizens lived) due to yellow fever each summer must have been a consideration in Governor Fleming's decision to call a special single-issue session of the legislature.

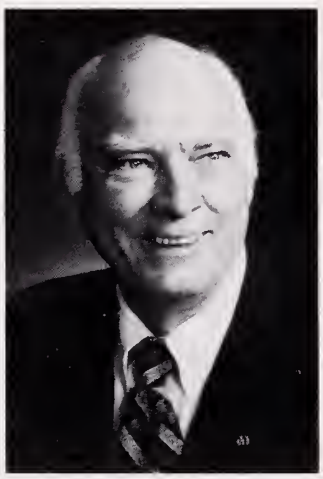
Acknowledgments

Since I have borrowed so widely and totally without shame, I would like to acknowledge the help and support of William M. Straight, M.D., for his classic works on yellow fever and many other historical tidbits; James M. Ingram, M.D., for his classic historical studies of physicians J.P. Wall, Oppenheimer, and others, Elizabeth and Norman Vickers, for their classical historical articles on Pensacola's early medical history, and Webster Merritt, M.D. (deceased), for his classic "A Century of Medicine in Jacksonville and Duval County." Many reference books on historical matters in Florida were introduced to me by these Florida libraries: Borland Health Sciences Library, Jacksonville, especially Mrs. Carolyn Hall; Haydon Burns Library, Jacksonville, especially Mrs. Arden Bruggs, Geneology Librarian; State Library of Florida, Dr. Dorothy Dodd Room, Florida Collection, especially Mrs. Barbara Matlich, Curator, and Mrs. Sharon M. Thompson, Geneologist, Asa May Family Search, Tallahassee.

• Dr. May, 13714 Veronica Drive, Hudson 33567.

Our medical heritage — a synopsis of the discipline of medical practice in Florida

William W. Cox, M.D.



Public health and the practice of medicine is an old story going as far back as the time of Moses. In fact, a major resource of medical doctrine in the Florida territory probably was derived from the teachings of pioneer physician philosophers of antiquity. It was through Moses that some of the first basic written principles concerning medicine and public health were identified. Later on, Hippocrates (460-377 B.C.), the first truly great physician, applied logic and reason to the practice of medicine. He endeavored to take the treatment of disease out of the hands of the priests and the religious systems, and, while not completely successful, an early start had been made in taking some of the mystery and spiritual taboos out of medical practice. He endowed the practice of medicine with sense of ethics and service to mankind which has persisted to this day. Many of his medical concepts as noted in his writings and in the Hippocratic Oath have, until fairly recently, been effective in maintaining a high quality of medical practice and an image of respect and appreciation for the profession by the community it serves. Much later in medical history, a Jewish physician-philosopher, Maimonides (1135-1205), who practiced in the Egyptian Royal Court during the Middle Ages, contributed significantly to the development of medical practice and to the understanding and codification of Mosaic principles of medicine and sanitation.

In addition to the teaching and writings of these early medical pioneers, other peoples of antiquity, i.e. the Greeks, the Romans, and the Egyptians, had developed sanitation principles and standards dealing with water supplies, waste disposal, handling of meat products, adulteration, etc., which were in general usage, especially in the urban areas, and which were passed on down to succeeding generations.

The aboriginal Indians, in the view of many authorities, came from Asia, across the Bering Strait, down the Pacific Coast, and then eastward to the Atlantic Coast and southward to what is now Florida. Although there are not written records, undoubtedly they must have brought with them many of the health customs and sanitation practices picked up from their original lands and from their travels.

Archeological interpretations of data resulting from studies of artifacts found upon excavations of tribal burial grounds suggest that Florida was inhabited by semi-nomadic peoples for many years before the birth of Christ. These studies indicate that prior to the advent of the white man, the Indians were relatively healthy and free of infectious diseases. The pre-Columbian days of the Indian tribes in Florida were, perhaps, the golden period of their medical history. Then the Europeans came, bringing with them smallpox, cholera, yellow fever, venereal

The Author
WILLIAM W. COX, M.D.
Dr. Cox is the Director of Public Health Unit of Volusia County.

diseases, hookworm, malaria, diphtheria, typhoid fever, tuberculosis, measles, and a host of other diseases. The health and well being of the Indians in Florida were never the same again.

Many of the health customs of the Indians that were in usage before the arrival of the white man were similar to the early Hebraic concepts of the "clean and unclean." These were concepts which dealt with food preparation, sanitation, personal hygiene, isolation of the sick and wounded, and many other similar hygienic practices. The role of the medicine man (the shaman) in the health culture of the primitive Indians was not well understood or appreciated until after the arrival of the French, Spanish, and English. The medicine man and his activities were closely identified with religious beliefs and in his priestly role his incantations to the Great Spirit were thought to be essential in warding off the evil spirits which were associated with sickness and misfortune. He did however have a large repertory of medicines made from roots, berries, barks and herbs which had been passed down from preceding generations. Some of our present day drugs — salilcylate, quinine, belladonna, curare, etc. — were old medicine man trade secrets which have been re-discovered by the white man. The discovery of many ancient artifacts and from legends handed down suggests that the medicine man had capabilities in a number of areas of medical practice. For example, he could perform minor surgery, set fractures, and assist in certain birthing procedures. In the area of preventive medicine, he utilized the practice of purgatives in the form of "the black drink," or hot baths and sweat baths on a community basis. Another widespread technique for the prevention or cure of illness was found in the practice of blood letting. The medicine man, using a sharp mussel shell or bird claw or beak, would make a small incision into an arm or leg until a free flow of blood was established and the evil spirits let out.

All of the available information about the medicine man and his times indicates that he was a dominant force in the society and culture of the Indian tribes in Florida. He was revered and respected by members of the tribe, not only for his medical prowess and accomplishments, but also as a spiritual leader, counselor, judge, and law giver. As such, he was a fitting predecessor of our present day practitioner of the healing arts in Florida.

The arrival of the Europeans resulted in significant changes in Indian medicine and in Indian health. The Indians, with virtually no experience with infectious diseases prior to the entrance of the Europeans on the American scene had very little natural or immunological response in coping with these new diseases. As a result, the tribes were decimated and were reduced to a losing struggle in maintaining their very survival and tribal identity. This, along with the inability of the tribes to develop a livable and competitive educational, political, and economic base soon led to the demise of most of the Indian tribes in Florida.

Tragic as was the impact of the Spanish, French, and English invaders on the health and welfare of the Indians in Florida, health conditions among the early white settlers were little better. Stress, malnutrition, trauma, and infectious diseases such as yellow fever, diphtheria, scarlet fever, smallpox, and respiratory infections caused many deaths, especially among infants.

For the most part, the early settlers lived under a loose and ineffective discipline of medical practice which was a heritage of the Indian medical culture and from concepts which had been derived from the religious teachings of Moses, Hippocrates, and Maimonidies. Apprentice-trained physicians, minister-physicians, barber surgeons, apothecaries, blood letters, midwives, and quacks were the primary available medical resources of the times. The lack of the so-called well-trained physicians in this group was not as serious as it might appear. Even in the best of medical practices of the day traditional utilization of calomel, opium, bleeding, blistering, purging, vomiting, and sweating was widespread. It hardly seems likely that patients afflicted with any of the usual diseases of that time would be seriously deprived by not getting this treatment. These were the primitive medical conditions that existed in the Florida Territory when it became a state in 1845 with a population of approximately 60,000.

It was not until statehood and the beginning of a well-structured and viable society that it was possible to develop and support a medical profession that could significantly impact on public health and the practice of medicine in Florida.

Following statehood and the formation of individual counties throughout the state, emphasis on the development of medicine focused on the establishment of local medical societies. It was from these societies that the beginnings of public health services in Florida emerged. As the ranks of medical practitioners expanded and the number of local medical societies grew it became apparent to the leaders of these societies that a state medical association would be necessary if the best interest of medicine was to be served. The Florida Medical Association was then formed and at its second meeting, February 17, 1875, in Jacksonville, the constitution of the Florida Medical Association was adopted with A. S. Baldwin, M.D. as its first presiding officer.

One of the first objectives of the Florida Medical Association was the creation and development of a State Board of Health. Under the outstanding leadership of John P. Wall, M.D., of Tampa, who made the following statement concerning the relationship of government, health and the well-being of the people: "The duty of preserving the health and lives of the

citizens from the causes of disease is as encumbent on the State as is that of supressing rapine and murder. One has no adequate conception of how much sickness and consequently death are preventable. The time is fast hastening when the preservation of the public health will become one of primary consideration in all enlightened governments.'' Fourteen years later, at the insistence of Dr. Wall, who was a member of the Constitutional Convention of 1885 in Tallahassee, the framers of the State Constitution inserted the words ''the Legislature shall establish a State Board of Health.'' This became a part of Article 19 of the present State Constitution. In spite of this background it took an epidemic of serious proportions to prod Florida into the realization that something had to be done about public health. The epidemic of yellow fever in 1888 that began in the Keys and moved on up to Jacksonville was the stimulus that was needed for action. The ''shotgun quarantine'' procedures at county lines against travel and commerce and a rising fear and concern of the people made it plain that a state organization was sorely needed to administer protective measures for the people and yet control fear and unreasonable restrictions on travel and trade. Because of this, the new governor, Francis P. Flemming, called a special session of Legislature for the purpose of creating a State Board of Health. It was signed into law on February 20, 1889. Programs such as veterinary public health services, maternal and child health services, dental public health services, environmental health, laboratory services, analysis of vital statistics, nutrition, licensure and professional regulations, health education, and coordination of activities and resources which was to be used in school health programs, formed the core of the early efforts of the Board of Health.

The first State Health Officer was Joseph Y. Porter, M.D., who was born in Key West on October 21, 1847. He graduated from Jefferson Medical College with the degree of Doctor of Medicine in 1870. Dr. Porter served the people of Florida in this capacity for 32 years, from 1885 to 1917.

Public Health services in Florida began at the local level in the days when cholera, smallpox, yellow fever, and bubonic plague were the scourge of the coastal ports of St. Augustine, Key West, Tampa, and Pensacola. Under the leadership of Dr. Porter, these diseases were soon abated. During Dr. Porter's tenure the basic foundation of public health service in Florida was established and, with some additional modification, is in effect to this day.

The State Board of Health, in spite of its tremendous impact and success in developing public health in Florida, was abolished by the Constitution Revision Commission in 1969. It was replaced by the Division of Health and finally by the Department of Health and Rehabilitative Services. It was thought that resulting decentralization and streamlining of health agencies would lead to more effective and efficient health services. The DHRS was reorganized in 1975 and functions at present as the principal health unit of Florida State government. About this same time, a primary objective of the Florida Medical Association was the establishment of a separate State Department of Health with Cabinet rank. Unfortunately for medicine in Florida, this objective was not accomplished.

A second milestone in the development of public health in Florida occurred in 1931 when the Legislature enacted the ''Local Health Unit Law.'' This legislation made possible the establishment of County Health Units in all of the 67 counties of Florida by assuring administrative and budgetary support at the State level.

Programs and activities in County Health Units may vary widely depending on many factors such as economic, demographic, climatic, ecologic, etc. Early in the development of public health programs in Florida, the primary emphasis was on preventive medicine. There were certain areas of practice that public health units did not emphasize, such as diagnosis and treatment of acute illness of the medical indigent, the delivery of maternity cases, or the giving of material assistance such as found in today's welfare agencies. However, with the increasing needs and requirements of the medically indigent in a modern society, this situation has been slowly recognized by health, social, and political interests. Appropriate legislation has recently been enacted which deals with the problem of complete and continuing medical services for the indigent.

It was not until the studies of Abraham Flexner on the inadequacies of medical schools in the United States which were published in 1910 that medical training and the caliber of physicians improved. Because of this and the advance of the basic sciences, the practice of medicine and public health in the first part of the twentieth century in Florida was increasingly professional. This was a period of medical stabilization, discovery, and expansion. It was characterized by almost idealistic patient-physician relationships, the development and wide usage of immunization vaccines, new antibiotics, radiological and laboratory techniques, construction of hospitals, clinics, and medical schools, and by an emerging appreciation and respect of the physician and his profession by the public. The medical profession flourished because a great need was being fulfilled. Many state laws and regulations were adopted which contributed to the strength, unity, and quality of medical practice. It was a time when the physician, in addition to being the medical advisor to the family was also frequently a personal family counsellor and confidant. It was a time when house calls were a necessary and accepted form of medical practice. It was a time when the oath of Hippocrates had a mean-

ingful significance from the standpoint of medical philosophy and application in medical practice.

Several years ago favorable times for the practice of medicine in Florida began to slowly erode. Technologic advances in medical practice had developed much faster than the social, legal, regulatory, political and economic systems which are so necessary to the satisfactory solution of the many problems engendered by these rapid and sophisticated advancements. As a result of this, specialization in medical practice became an increasing trend and this, along with other factors, led to a steadily advancing cost of medical services. The training emphasis in medical schools seemed to be focused more and more on developing physicians who did not feel secure in their practice unless they were in the shadow of a nearby hospital or a well equipped central medical laboratory. The era of the paternalistic Fildes' "Doctor" of portrait fame was coming to an end.

Government, political, legal, and economic interests in medical practice in the period following the midpoint of the twentieth century was becoming increasingly manifest as noted by the high expenditures on medical and social welfare programs at the national, state, and local levels. The dictum that free access and use of medical services was a right of all the people rather than a privilege of the monied few was increasingly accepted at all levels of society and government. At the national level the introduction of medicare and medicaid programs in 1965 as well as more recent innovations such as diagnostic related groups, pre-payment plans for medical providers, antitrust rulings, malpractice and liability litigations, etc. have all placed encumberances on the free practice of medicine that has caused confusion and disarray in the ranks of the individual medical practitioner.

In addition to the government and political interest in providing medical services to the people, other groups such as health maintenance organizations, hospital based physicians' groups, corporate owned for-profit medical providers, and many other like organizations have entered the medical field. Marketing and advertising by physicians, hospitals, clinics, and other health facilities, which was practically unheard of twenty-five years ago, is now commonplace and is going on to the extent that the distinction between the business of medicine and the profession of medicine is becoming less and less perceptible. For example, a large hospital corporation now owns over 40 for-profit hospitals and clinics in Florida. These new and additional medical providers have resulted in the development of a serious competitive spirit in medical practice which, if not corrected, could ultimately lead to medical practice at the trade level.

Are the problems facing medical society running out of solutions? Sophisticated techniques and research in organ transplants, space medicine, surrogacy, and the like are necessary to the continuing progress of medical science but not at the expense of other basic medical needs such as women who do not get adequate prenatal care, low birth weight babies, children who do not get appropriate nutrition or immunizations, the medical indigent who does not have access to quality medical services, etc. It would seem that medical priorities are in need of review and adjustment.

In the early part of this century, physicians were not particularly concerned with malpractice litigation because these types of legal procedures were rather infrequent. As a result of this, liability protection could be obtained at reasonable rates and the costly practice of defensive medicine was not widespread. Medical practice in Florida in this era was characterized by individual office practice in which the physician-patient relationship was that of mutual respect and trust. The costs of medical services were reasonable and could be adjusted to the financial level of the patient. Services to the medically indigent were provided by physicians, hospitals, and by public support on an almost gratis basis. In the complexities of living in today's fast track society, however, the good times of old have gradually faded away. Medical services in Florida and elsewhere have become excessively costly. This has not resulted because of "greedy physicians" as frequently portrayed by the media to a susceptible public, although there may have been some of that, too. The increased sophistication and complexities of modern medical practice in which large numbers of people are engaged in providing medical services which hitherto had never been available to the citizens of Florida has obviously been costly. The increasing development and availability of expensive, high quality, specialized medical services along with excessively costly liability insurance premiums and frequent unreasonable judgements in favor of the plaintiff have almost put essential medical services out of the financial reach of the average Florida citizen, especially those who may be without adequate third party coverage. With a legislature that is almost dominated by the legal profession and a judicial system which was devised and operated by them, it should not be surprising that the legal impact on the practice of medicine in Florida has had an unfavorable and devastating influence on the manner of medical practice throughout the State.

With one physician in four in Florida being the subject of a malpractice litigation at some time in his career, many physicians are reluctant to provide low cost or free medical services to the indigent as this group, too, has been identified as a good source of prospective clients for the ubiquitous wiles of the legal profession. While it is true that some of these legal actions are the result of the practices of the incompetent physicians, they are significant factors only in a small minority of cases. These incompetents are

gradually being weeded out by corrective actions of the local county medical societies and by the State Board of Medical Examiners. In any event, the earlier doctor-patient relationship of mutual trust and respect which is the core of medicine and makes it the most human of the bio-sciences is being challenged, undermined, and replaced, in many instances, by a nonproductive physician-patient adversarial type of relationship. Indeed, some of the basic concepts of the "art" of medicine and its tenets are at risk.

As someone has said, it almost makes one long for the return of " the good old days" of the 1960's and 1970's when the practice of medicine seemed so much simpler and fulfilling. In spite of all these unsolved difficulties, however, good medicne is still primarily concerned with the patient, the physician, and the quality of the relationships that exist between them.

It can be expected that the present confusion and uncertainty in medical practice in Florida may lead many young physicians to opt for practice within a corporate or government facility with its assured income, fringe benefits, and free time as opposed to private practice with its social and economic uncertainties. This could develop into a trend which could adversely influence the practice of medicine in Florida for many years to come.

The state Legislature has devoted much time and study to programs that would contribute to a solution of one of the outstanding medical dilemmas facing society, i.e. "how to provide high quality medical services to the indigent on a cost effective basis?" As a result of this and in addition to the federal and corporate health programs, the Legislature in 1984 passed an innovative medical program, the Health Care Access Act, which provided for the development of a high quality family oriented primary health care program for low income citizens of Florida. The program was designed to establish a structured and coordinated system of preventive medicine, primary care, and consultative medical services in a "medical home" type system for the medically indigent. This program seeks to bring together in a united effort the input of government, county health units, and the private sector of medicine in providing optimal medical services to indigent patients on a cost effective basis. This would involve the transfer of non-emergent medically indigent patients out of the expensive hospital emergency room setting to nearby primary care clinics operated by local county public health units. The program allows for the operation of the primary care units directly by the public health units themselves or for indirect operation by contracting these services out to other appropriate, non-government or independent health agencies and facilities. A number of counties in Florida are already in this program. Sufficient data has not yet developed to judge absolutely its success, however, early indications are that it is fulfilling its expectations. Should the program prove to be successful, it is planned to extend it throughout the state.

Finally, and in a synoptic manner, the development of medical practice since its earliest times in Florida has been outlined up to the present time. Indeed, at the present time, it would appear that the very basic foundations of a good medical practice that has provided for many years the world's best medical services to the community are threatened with radical and permanent change.

Will this new order of medical practice provide for the greatest good for the greatest number of people on an affordable basis? The jury is still out on this question and it is being weighed in the balance. The final outcome may not be known until the clashing interest of disparate factions have come to some equitable solution.

The medical profession today seems to be in a situation that parallels, in a sense, the sad events depicted by the bard in his lament on the passing of Arthur and his Knights of the Round Table of Camelot fame:

> And slowly answer'd Arthur from the barge:
> "The old order changeth, yielding place to new
> And God fulfils himself in many ways,
> Lest one good custom should corrupt the world."

Acknowledgements

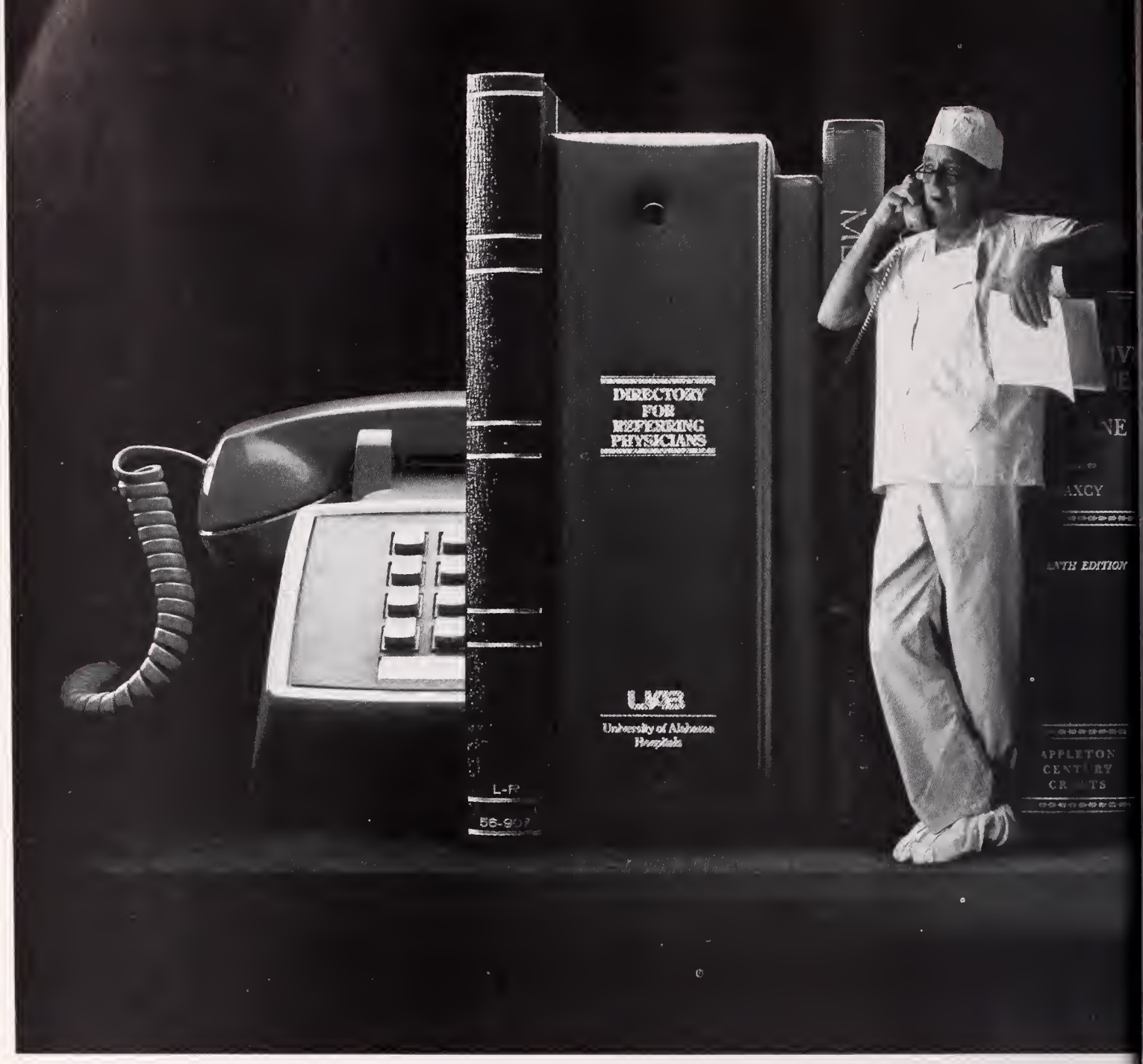
The author gratefully acknowledges the following individuals and organizations who gave valuable assistance in the preparation of this article: County of Volusia Library Center; Borland Health Science Library, Jacksonville, Florida, Carolyn Hall, Librarian; Charlton Prather, M.D.; Mrs. Janice Scott, Health Educator.

The views expressed in this article are those of the author, and no official endorsement by the Florida Department of Health and Rehabilitative Services is intended or should be inferred.

References

1. Miscellaneous papers and documents on the development of public health in Florida from the Borland Health Sciences Library, Jacksonville, Fla.
2. Florida Health Notes from 1892.
3. Editorials and notes from *The Journal of the Florida Medical Association.*
4. "A Summary of Florida's Health Under Eleven Governors," a monograph, William T. Sowder, M.D., M.P.H.
5. "Florida's Last Frontier," Charlton W. Tebeau, University of Miami Press, Coral Gables, Fla., 1966.
6. Excerpts From the Constitution of the State of Florida.
7. "General Amherst and Germ Warfare," Mississippi Valley Historical Review, Jan. 19, 1955.
8. Contempo '85, JAMA, Oct. 25, 1985.
9. Journal of the Senate, State of Florida, May 26, 1975.
10. "The Healers," John Duffy, University of Illinois Press, Urbana, Ill.
11. "Changes," an editorial by Dr. A. D. Bricker in the *Journal of the Florida Family Physicians*, Winter, 1985.
12. "A Services Integration Update," Laurence Lynn, Evaluation, April 1977.
13. "How Florida Reorganized its Health and Rehabilitative Services," William J. Page.
14. Mallory, "Le Mort D'Arthur," as noted in the Idyles of the King, Alfred, Lord Tennyson.
15. "The Fall of Troy," Bullfincher Mythology, T. Y. Crowell, Publisher.

- Dr. Cox, Volusia County Public Health Department, 501 Clyde Morris Blvd., Daytona Beach 32014.



MIST brings our Cardiovascular



The Division of Cardiovascular Disease provides clinical services in all aspects of disease involving the heart and blood vessels. Faculty members within the division present a broad range of special interests and expertise, including:

Cardiac Arrhythmias • Cardiac Angiography • Valvular and Congenital Heart Disease • Coronary Artery Angiography • Ischemic Heart Disease • Hemodynamics • Radionuclide Imaging of the Heart • Holter Monitoring • Electrocardiography • Cardiac NMR • Digital Subtraction Cardiac Angiography • Echocardiography • Coronary Angioplasty • Hypertension • Coronary Artery Thrombolytic Therapy

The division performs all the traditional as well as the newest diagnostic and therapeutic procedures.

Inpatient services are provided in fifty beds maintained in the University of Alabama Hospitals, including seven in a specifically maintained and



sease Specialists into your office.

ipped Intensive Evaluation Unit.
he Division of Cardiovascular Disease is one of
departments and divisions of the University of
ɔama Medical Center accessible to you through
dical Information Service via Telephone (MIST).
y dialing the MIST number you have access to
lty specialists seven days a week, 24 hours a day.
nsultation, referrals, and transfers via the Critical
e Transport Service are as close as your phone.

Consult With A Specialist, Call

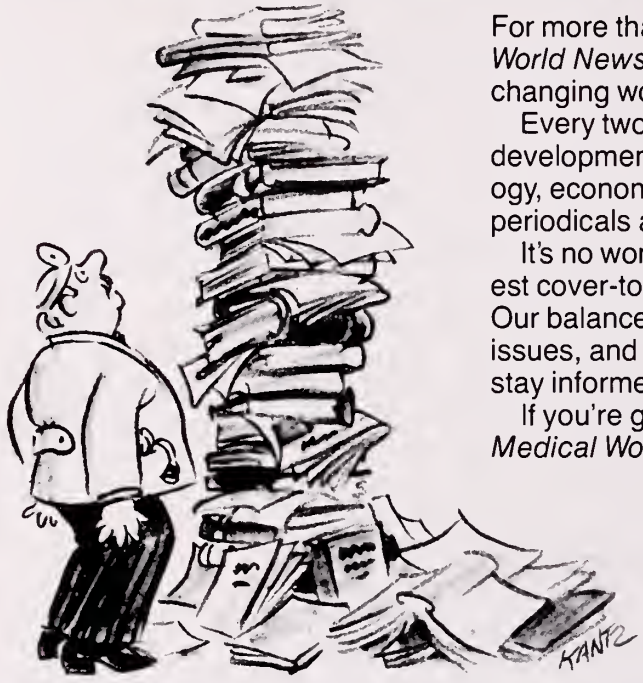
MIST:

1 800 292-6508
IN ALABAMA

1 800 452-9860
OUTSIDE ALABAMA

UAB The University of Alabama at Birmingham

Getting behind in your medical reading? Let *Medical World News* put you ahead.



For more than 115,000 busy physicians like you, *Medical World News* is the secret to staying informed about the changing world of medicine.

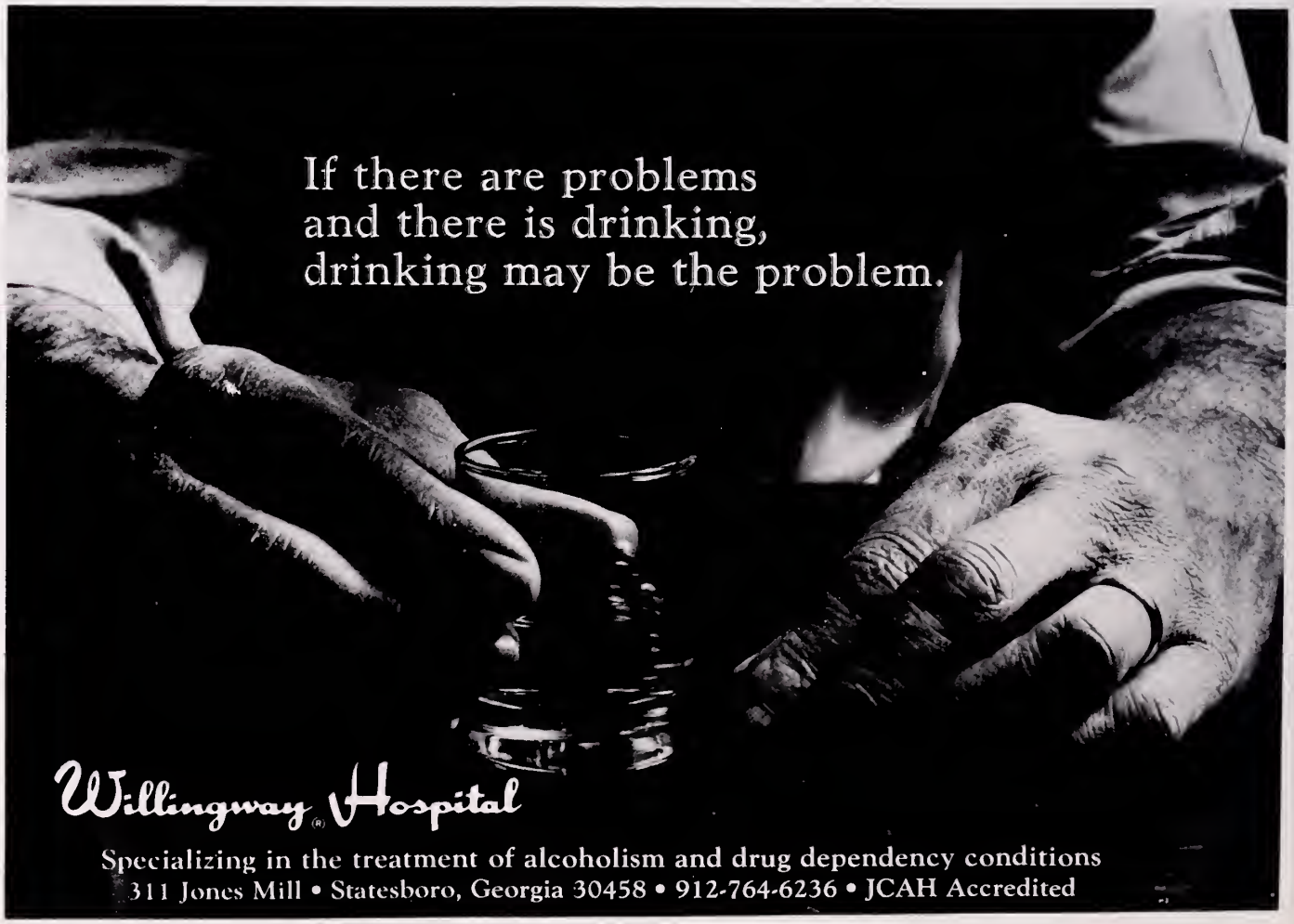
Every two weeks, we will bring you up-to-the-minute developments in therapy, research, practice, pharmacology, economics, legislative action, highlights of other periodicals and new medical trends.

It's no wonder *Medical World News* has one of the highest cover-to-cover readerships in medical publishing today. Our balanced reporting means you'll get all sides of the issues, and our fast-reading style makes it enjoyable to stay informed.

If you're getting behind in your medical reading, let *Medical World News* put you ahead.

medical world news The credible source.

©1986 HEI Publishing. All rights reserved.



The elements of power

Last month's article initiated an exploration into the elements of power — its sources and the mechanisms by which it is enforced. Power was defined as the ability to influence others to one's own way of thinking thereby subjugating decisions, events and people to one's own advantage. Alternative definitions can be offered but this one serves the purposes of the medical profession.

Historically power is derived from three sources: the personality of the leader, wealth, and the organization. Of these, organization is the most potent. The other two are limited. The power of a leader in twentieth century society vanishes with the leader's overthrow, resignation or death. Money or property was an important source of power in past centuries in more agrarian economies but its influence has waned with the redistribution of wealth and the ascent of the service sector in our society. The organization embodies the quintessence of power. It fosters natural allegiance, stimulates internal discipline, concentrates wealth, and harnesses leadership to the purposes of the organization. It also can perpetuate itself beyond the time limitations inherent within a single personality. There are three instruments by which power is implemented: by punitive action, by remuneration, or by persuasion.

The first of these is punitive power and this may be violent. The march of history is a calvacade of reports of man's attempts to dominate his fellow man by violence. Governments continue to wage war and to inflict capital punishment. Parents use corporal punishment to establish order within the family structure and children use milder forms of violence on their siblings or playmates. Violent punitive power is obviously not appropriate for physician use.

Punitive power does not depend upon the infliction of corporal pain upon another. Punitive power can be exercised by depriving or threatening to deprive the subject of some valued benefit. Employers can inflict their will on their employees by the threat of job loss to the employee who does not conform. In the middle ages the church maintained its power over the common man by instilling the belief that salvation would be denied to those who failed to follow its teachings. The church was able to extract obedience from rulers and the military by the threatening the transgressor of its integrity by excommunication from church membership. Governments maintain law and order by threats of incarceration and the loss of the personal freedom of miscreants.

Punitive power of the deprivation type is also not appropriate to medicine. The nature of our profession ethically and morally prohibits us from denying our services to those who require it.

Today, compensatory power is the most common way by which individuals enforce their will upon or earn the assistance of others.

The second tool by which power can be implemented is by compensation. Historically military leaders and rulers rewarded their supporters with grants of land or titles or by sharing the spoils of victory. Individuals purchased the cooperation of politicians and government authorities by bribes or other economic awards. Politicians assured their election by buying votes. Today, compensatory power is the most common way by which individuals enforce their will upon or earn the assistance of others. Employers pay wages to employees; banks pay interest to depositors; political action committees donate money to the election funds of politicians.

The power of compensation does not need to be expressed only in monetary terms. Positive emotional reinforcement such as praise, pleasant working conditions, the attachment of a title to a job, and the opportunity for fame, prestige or scholarly excellence are forms of compensation.

Compensatory power could be exercised by contributing to the campaign of legislators but physicians' economic resources are too insignificant to effectively alter the current legislative climate by political contribution. Thus, compensatory power has limited, if any, applicability to current medical problems.

The third mechanism of exercising power is by persuasion. Persuasion permits one to convert the mindset of apathetic or even hostile individuals or groups into vigorous supporters. Mark Antony's speech to the Roman populace (as created in Shakespeare's Julius Caesar) is a classic example. Rhetorical devices can be utilized to transmute the hostility and anger of a crowd into affirmative and emotional support.

Persuasion assumes many forms and utilizes many different techniques. The politician uses radio and television to convince the electorate of his supreme worthiness to hold office. Advertisers create a need and demand for their products. Books, journals and pamphlets are used to promote concepts, theories or opinions on multiple issues. Scientific articles are written to convince us of the accuracy of the researchers' observations and the correctness of the conclusions expressed.

The audience of the persuasive barrage will be converted and convinced if the issue (or product or idea) is pertinent to their own life needs, if the message presented is understandable, intelligent, and credible and if they feel that the acceptance of the message will be advantageous for themselves. The most persuasive people derive recognition, prestige, money, elective office, or favorable legislation as their reward.

The development of persuasive power is a subject worthy of lifetime scholarship and volumes have been written about it. A few important qualities of successful persuasion include a clear definition of the message; the proper identification of the target group or constituency; the correct selection of the language, the visual and auditory techniques that will be used to transmit the message, and the use of the appropriate media or environment through which it will be communicated.

Persuasion is the only power instrument available to physicians. Yet physicians are accused of being poor communicators. They communicate well among themselves but poorly with the lay public. Not only are their messages opaque but they are often directed towards the wrong recipient. For instance, doctors have consistently lost the skirmishes over the malpractice crisis. One reason is that they have waged the battle in the wrong arena. They have attempted to resolve it within the legislation locale and they have directed their messages towards the legislators. The milieu and the target population they have selected is too confining for success. The malpractice problem will not be resolved until the entire citizenry recognizes that the high cost of liability insurance is not just a doctors' problem but that it is society's problem. That lesson has to be directed towards the entire population and not merely at the state legislators who have other concerns besides the needs of physicians. Similarly, cutbacks in Medicare and Medicaid will not be appreciated as deleterious until both the young and the elderly become convinced that such cutbacks will deter disenfranchised beneficiaries from seeking and receiving proper care for controllable diseases and that absence of care today will result in greater expenditures for medical care in the future. The public perceives the current cutbacks as necessary and beneficial to control costs. They do not recognize that such cutbacks might curtail access to and reduce the quality of medical care. The current efforts of organized medicine to influence legislation might be more successful if they were focused on educating and persuading the public rather than being directed only at the legislators.

Physicians' control of medicine depends upon their support and allegiance to a strong organization that represents the social, economic and political needs of medicine.

We have learned that power springs from three sources: the personality of the leader, economic strength, and the organization; and that power is implemented by three mechanisms: by punishment or the threat thereof, by pecuniary or egoistical remuneration, or by persuasion. Can physician's apply these precepts to their own advantage? Absolutely. If physicians are to maintain control of medicine, they must recognize and selectively utilize the sources and instruments of power available to them. Since the preeminent source of power is the organization, physicians need to utilize and devote themselves to a strong organization. Since their ultimate instrument is persuasion, they need to focus their attention on eliciting sympathetic public opinion.

Physicians' control of medicine depends upon their support and allegiance to a strong organization that represents the social, economic and political needs of medicine. Since the American Medical Association has the structure and decades of experience necessary to represent our needs, it seems prudent to strengthen the AMA rather than to develop a new organization for these purposes.

The organization chosen by doctors must provide three indispensable items: 1) a well-defined purpose that is clearly stated and widely supported by the overwhelming majority of doctors; 2)a strong and knowledgeable leadership not only at the national but at the county and state levels; and 3) financial and personal committments from the membership to implement the measures necessary to accomplish its stated objectives.

The objectives of organized medicine must integrate the needs of physicians with those of American society. Sixty years ago the AMA programs promoted scientific medicine over homeopathy, supported vaccination and other public health programs and initiated post-graduate medical education. These activities were recognized by both government and the public as goals that were advantageous to the public welfare. This commitment to the public needs ultimately resulted in the economic and social betterment of physicians' status. Today the public assumes, as a given right, the goals that were promulgated by organized medicine sixty years ago. The public forgets that organized medicine was responsible for effecting these goals. The public forgets to credit organized medicine for its past accomplishments.

The public forgets to credit organized medicine for its past accomplishments.

When I ask my patients to tell me about their major concern regarding medicine, the answer is uniform — it is the high cost of medical care. Their main concern is not medicine's quality nor the physician's capability to deliver it, nor public health issues such as cancer prevention. Most patients want to reduce the cost. The citizenry attributes the high cost of medicine to the doctor. After all the doctor orders hospitalization, high-tech diagnostic and treatment modalities, high-priced medication, and then charges high fees for surgical and other services. The doctor is correctly perceived as the individual who spends the health care dollar. The patients' logic flows as follows: since the doctors are responsible for directing expenditures, they must be responsible for the high cost of medical care. Obviously there is a fallacy in this argument, but the public, the legislators, and the bureaucrats are unaware of the fallacies. Many of these fallacies have been discussed briefly in previous articles in this Economics series. I will reiterate just two of them. The first fallacy is that the cost of physician services has exceeded the pace of inflation and the rise in income of the general population during the last two decades. As referenced in an earlier article, this is not true. Fallacy number two is that unnecessary surgery and hospitalization are contributing to the increased cost for medical care. A study of Schroeder, et. al. has belied this and has demonstrated that the increased cost for medical care can be attributed to wider use of more expensive technology such as CT scanners, cardiovascular surgery, neonatal care units, and intensive care units. A larger portion of the more expensive care is being assigned to the care of terminally-ill elderly.

One of the objectives of organized medicine should be to aggressively publicize and correct the misconceptions about the causes of high cost of medical care. Organized medicine further needs to educate the public that the increased cost of medical care may not be harmful. As medical expenditures have increased, longevity and quality of life have improved.

Organized medicine needs to have other goals besides that of public relations. It should strive to create and test alternate methods of financing health care. Any health care system devised, however, must accomodate health care for everyone who is willing to use it and comply with it.

Obviously the organization of medicine must meld its goals with current and future public needs. If a piece of medical legislation is unfavorable to the long-term benefits of society, medicine needs to identify the legislation as harmful and needs to present its case to the public and not just to the legislators. The failure of medicine to interdigitate its goals with those of society will deprive physicians of their capacity to direct the future of medical care within this country.

Once organized medicine has chosen and defined its prime objectives and has identified these as compatible with public needs, it has to stimulate its membership to work cohesively to accomplish the stated objectives. Local leaders must rouse the membership to support medicine's program. This will be difficult. When I speak at county medical society meetings throughout the Southeast I note a lack of local leadership and wholesale apathy of physicians towards medicine's problems. I hear grumbling about the current changes that confront us but I hear no discussion of possible solutions or willingness to resolve the problems. Disinterest and negativism must be reversed.

Doctors must also pool their economic resources to accomplish medicine's goals. This will require greater contributions from all of us. But the success of our programs will transform this expense into a high return investment. Physicians are reluctant to invest in their collective futures. The benefits to be derived from the programs of organized medicine have to be accurately and carefully estimated and clearly delineated if physicians are to be persuaded to contribute economically to a unified national program.

The individual physician must be recruited into any campaign of persuasion that organized medicine

conceives. Individual physicians have lost sight of their power to alter the opinions of their patients regarding matters that pertain to social-economic issues of medicine. Doctors will alter the opinions and voting patterns of legislators and the decisions of policy makers only if they can summon the support of their patient populations. Each physician must therefore educate his own patients about the long term consequences of present policies and future legislation. Physicians can distribute brochures in their waiting rooms, distribute information sheets in the monthly statements, briefly discuss the issues with the patients, air their opinions on radio and TV, and write editorials and articles to the local newspapers. They must win the support of the patient population to assure the continued quality of the medical care system in this country.

If individual physicians are to participate in the persuasive programs of orgainzed medicine, they need to be informed. Facts and knowledgeable opinion about medical policy will have to be rapidly transmitted from the national organization to the individual doctors. Well informed patients can assure the success of the objectives of American medicine.

Most physicians do not reflect upon the elements of power and fewer consciously apply them. As a result, the political power of physicians has dimmed. Their economic and social welfare will continue to decline unless they recognize and actuate the power process.

Jacques R. Caldwell, M.D.
Daytona Beach

A reply to Dr. Caldwell

The article which appeared in the February, 1986, issue of *The Journal* by Jacques R. Caldwell, M.D., entitled "Unionism: An Inappropriate Treatment for Medicine's Ills," is an example of the eruditeness that physicians so often bring to a sociohistorical analysis of an economic and ethical issue; but eruditeness can still be superficial and not grounded in current realities, as Dr. Caldwell's article aptly demonstrates. As one who has been closely involved in the application of existing labor theory to the physician work force, I feel several points that Dr. Caldwell makes should be more carefully explored.

Dr. Caldwell is correct in most of his description of the factual history of the social and economic forces which have shaped the union movements in American labor during the first part of this century. Paul Starr, Ph.D., in *The Social Transformation of American Medicine*, has similarly discussed the factors which set physicians apart from other craftsmen and professionals and allowed medicine to remain a sovereign profession despite the stresses of continued industrialization in the twentieth century, thereby delaying medicine's current confrontation with modern corporate entities and their management. This century has revealed technological change to be a major force in the shaping of culture and resultant socioeconomic policy.

As medicine has become more dependent on rapidly advancing technology, the socioeconomic position of physicians in American society has come to parallel more closely that of the skilled craftsmen and cottage industries which found themselves being assimilated by corporations throughout the late nineteenth and early twentieth centuries. Now, in medicine, as in the labor movements of the 1930s, we see unionism as a response to the industrialization of a formerly sovereign profession. This is occurring for many of the same reasons that it has already occurred in many other trades and professions: preservation of an optimal working place (even if a so-called "private" physician's office), improvement in working conditions (few would deny that third-party payors are a major determinant in how the business of our offices are structured) and appropriate renumeration for services that are still of no small worth to society. If Dr. Caldwell does not feel that the socioeconomic and corporate forces driving the dynamic changes that are occurring in medicine are not at least as profound for our generation of physicians as those that affected the workers during The Depression, he is not living in the same world that I and my Union colleagues find ourselves. Once again, the three "supporting credos of American economic thought" from the Adamsian school of American economics are being rejected by physicians because of corporate incursions into the quality of care and ethical issues affecting medical practice.

Dr. Caldwell would make the point that American labor unions have seen a decline in growth and economic influence since the 1960's. Surely he is aware of the "natural history" of labor unions: most of the important battles for American workers have been won, and the rationale for existence of traditional labor unions in the non-professional work force has been threatened by its success. The lack of unregulated trade and the influence of cheap labor available abroad on American industry and commerce have undoubtedly played a dominant role in the decline of many American industries; indeed, until the labor movements in foreign countries "catch up" with that in the remainder of the industrialized world we can expect that multinational corporations will take every advantage of such disparities. The forces of history would dictate that the current situation would have come about at any rate and few knowledgeable persons

would deny that American workers have benefited from the protection won for them by organized labor in these changing economic times.

Popular newsprint, on the other hand, has been rampant with descriptions of the roles played by unions of professionals, notably the airline pilots and athletes' unions, over the last several weeks in contract negotiations for those and other professionals. This would seem to give some indication as to where the current need for unionism lies in today's American economy. There is a well-established body of labor law and negotiating theory which is only just now being carefully applied to the professional work force. Positive interpretations of these labor precedents will become increasingly essential for the continued social and economic success of individual physicians.

Reynolds, as noted by Dr. Caldwell, has described the theory that unions seem to derive their power by preventing replacement workers from working during a strike. The concern is then expressed over "internecine warfare" between union and nonunion physicians. This extrapolation is perhaps typical of medical anti-union thought and fears. It disregards completely the state of economic warfare that is already being propagated upon American physicians by corporate attorneys who are becoming increasingly successful at pitting corporate physicians (who frequently are also the officers of the local medical societies and the driving force of the current HMO fad, IPA, or hospital primary care clinic) against more traditional fee for service physicians. "Reduction in medical care costs" has become simply another marketing ploy for these physicians and their corporate paymasters.

The concerted efforts of the liability insurance companies and malpractice lawyers to devalue and disenfranchise physicians from their position of formerly high regard in our culture, thereby creating a similar state of "economic warfare" between physicians and patients, also go unsaid by Dr. Caldwell. I doubt that any union-nonunion-physician conflict would be nearly as brutal or economically disastrous as these two scenarios are proving to be, assuming of course, that the union remains successful in espousing the ideal of ethical physician-physician relationships as it has done for the last fourteen years. The only physicians the union will declare war with are those who place corporate profits above humanitarian and quality of care issues. The manifest attitude of American corporations toward their workers undoubtedly accounts for the ranking of American business only a little higher than non-professional unions and far below medicine in the polls, a fact that Dr. Caldwell failed to note in his article.

Again, in his discussion of the sources of physician prestige, Dr. Caldwell discusses Paul Starr's sociological theories, and then, having made appropriate conclusions about the limitations of physician "clout" possible with only 500,000 physicians nationwide (truly an economic minority), he extrapolates the poll findings above concerning non-professional unions to any physicians' union. He compounds this unwarranted extrapolation by an emotional discussion of tactics that have been used by many desperate minorities, not just unions, in their struggles for economic or social justice. However, he does not attempt to even imply that the UAPD has ever employed such tactics in all the years that it has employed successful negotiation on behalf of its contractual and fee-for-service members in California and other states. His assertion that a physician "paper strike" would be financially injurious to ourselves or our patients (rather than our third-party paymasters) is also invalid historically. There was only one known example of the use of such tactics by physicians until this week; both have been successful, the most recent in Washington, D.C., against a local HMO.

Finally, it should be noted that not even Dr. Caldwell attempts to include in the tactics legally available to medical associations any having to do with economic negotiation. Well he should not, for since the 1950s the FTC has brought no less than twelve anti-trust actions against the AMA when it attempted such activity. If physician contractual negotiations are so likely to be unsuccessful, then why has the AMA persistently attempted to enter this arena of endeavor for its frustrated physician members? The UAPD, on the other hand, has been scrutinized by both state and Federal watchdogs as required of a union two to three times a year for the last twelve years of its existence and has never had an anti-trust or unfair labor practice action instituted against the union. Medical associations would be well advised if they continued their historically successful efforts at public education, support of scientific medicine, and research and left economic negotiation to the union — as indeed labor law says they must.

The above record also speaks to the supposition that medical unionism "probably violates anti-trust laws." With 40,000 members in sixteen states, and a record of negotiations extending over twelve years, how much larger does the UAPD have to be before it is no longer "economically effette" and meets the test of "market forcefulness?" Even the structure of his argument finds Dr. Caldwell admitting that medical unions will become a force to be further reckoned with. Conflicts of interest and ethical considerations will continue to be evident in any other proposals that suggest that physicians should surrender the practice of medicine to the economic and profit goals of their corporate and third party paymasters, even if such acquisition occurs to the applause of those in government and law, and under the guise of "physician-corporate" partnerships.

Medical unions are therefore neither an historical anomaly or anachronism, but represent an identified

response of an (economically) persecuted minority in a free society. The question is no longer whether or not to unionize, but only when, and most of all, how quickly. We can assure Dr. Caldwell that reports of the Union's imminent demise in Florida, like Twain, are greatly exaggerated.

As the Bard has said, "diseases desperate grown, by desperate devices are relieved." Hopefully American physicians will not be completely terminal in their response to the further industrialization of medicine, and will acquire the insight to shape their proper role as caregivers in the continuing economic evolution of American society.

Arthur L. Hall, M.D.
Vice President
Florida Federation of the UAPD
Maitland

Dr. Caldwell's reply

I am delighted that the article, "Unionism: Inappropriate Treatment for Medicine's Ills" conjured up some spirited comment in dissent.

Dr. Marcus has assumed, because of the publication date in February, that the article was written in response to his comments before the Florida Medical Association Leadership Conference on January 25th. The article was researched and written prior to that conference and, as such, is not a rebuttal to his presentation. The accompanying letters by Drs. Hall and Glatzer effectively present a pro-union response to the issue and are welcome, (see Letters and Viewpoints).

I vigorously agree with Dr. Hall's contention that medicine is experiencing dynamic changes. However, it is a bit hyperbolic to state that physicians are experiencing the same catastrophic economic conditions that affected workers during the Depression. After all, we are not unemployed; we are not threatened with, or experiencing starvation. We are not, as he implies, an economically "persecuted minority." I do admit that physicians are being unfairly blamed for the high cost of medical care and that the current government administration has unfairly penalized us but to exaggerate our current problems in such a way that they are unjustly compared to the sorrowful plight of the Depression workers is inaccurate and cruel. Maintaining such an excessive posture will only subject doctors to ridicule because the analogy is ridiculous.

I am fascinated by the existence of "a body of labor law in negotiating theory which is only just now being carefully applied to the professional work place." I feel the readers of *The FMA Journal* should be apprised of these "labor precedents" and I request that Dr. Hall, with the collaboration of one of his legal colleagues, develop an article elaborating upon them. However I do not share his sanguine outlook for the power of professional unions. I recall that the pilots who struck Continental Airlines are still unemployed. Most of the air traffic controllers who struck in 1983 have been permanently banned from carrying out their profession in the United States.

I also would welcome more information from Dr. Hall on "corporate physicians (who frequently are also the officers of the local medical societies and the driving force of the current HMO fad, IPA, or hospital primary care clinic) against more traditional fee for service physicians." I have lectured to 22 county medical societies in Florida, Georgia, North and South Carolina within the past year and have yet to observe any collusion between corporate HMOs, corporate PPOs, and medical society officers. Georgia has its own IPA but that is physician organized and owned and is a response of those physicians to the ingress of corporately owned PPOs and HMOs within their state. I have never observed that a corporate-owned HMO physician has even been a medical society officer. Dr. Hall needs to document and make us aware of how common this phenomenon is.

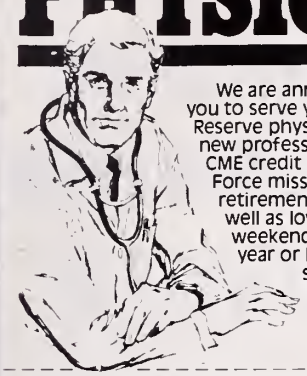
I respect Dr. Richard Glatzer's comment (see Letters and Viewpoints) that a public relations campaign is extremely important to counter any deceitful advertising by HMOs or any other group. I strongly feel, as evidenced by this month's and last month's Medical Economics articles, that public enlightenment by the medical associations is extraordinarily necessary.

Obviously I, like most doctors, feel that physicians should "fight back, preserve, and protect the medicine that we have and that we know without unions." We certainly will have to become more militant but we can do this without sullying our image by donning the mantle of unionism. In the last two issues of *The FMA Journal* I have very briefly explored the elements of power in the hope that their appreciation will arm physicians with a mode of proceeding in today's difficult times. Doctors Hall and Glatzer and I agree on one essential item. Medicine needs a strong organization to represent it in which it receives the fervid support of its members. However, I feel that medicine must lead with dignity and not upset society with shrillness of union tactics. Medicine must educate the public with a continual flow of accurate information but avoid barraging the public with a cannonade of propaganda.

We can resolve the current crisis — with leadership and strong cooperation but we do not need unionism to help us.

Jacques R. Caldwell, M.D.
Daytona Beach

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HQ 10 AF/RSH
Bergstrom AFB, TX 78743-6002

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Prior Service? Yes ___ No ___

Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE

Government Printing Office Bookstore

Jacksonville, Florida

The Government Printing Office Bookstore in Jacksonville, Florida carries in stock the International Classification of Diseases, 9th edition (ICD-9). This three-volume set contains the codes used in filing insurance claims. Price: $29.00 (paper edition) and $40.00 (cloth edition).

The book store also carries in stock four different formats of the HCFA Form 1500, used for filling out Medicare claims. The two-part carbonized snap-out form used most by doctors sells for $13.00 per 100-count package. Pre-payment is required, although there is no tax or no postage charge for 4th class mailings. Make check payable to Superintendent of Documents, or charge orders to MasterCard, Visa or Choice.

Government Printing Office Bookstore
Federal Building, Room 158
400 West Bay Street
Jacksonville, Florida
(904) 791-3801

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

THE MEDICAL SYSTEM INCLUDES:
- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

ADVANTAGES
- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

INTERESTED?
For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

The ISI Software Question

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

Thirteenth Annual Review Course for
Certification in Internal Medicine

"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"

August 17-30, 1986
Key Biscayne Hotel and Villas, Key Biscayne
Director: J. Maxwell McKenzie, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for certification in Internal Medicine. It will provide an intensive and comprehensive survey of those aspects of Internal Medicine which should be familiar to internists qualified for certification and recertification. Printed materials with references and self-assessment questionnaires will be provided to all registrants. This course will end ten days prior to the certification examination of the American Board of Internal Medicine.

A faculty especially selected for its expertise in review courses will present the following topics:

Week I	Week II
Cardiology	Infectious Diseases-Immunololgy
Pulmonary	Nuclear Medicine-Oncology-Genetics
Toxicology-Hypertension-Hepatology	Endocrinology
Renal-Acid Base	Gastroenterology
Rheumatology	Ophthalmology-Critical Care-Dermatology Laboratory
Hematology	Radiology-Neurology-Psychiatry

Highlights

State of the Art Lectures	88 credit hours in Category I
Patient Managment Problems	Self-Assessment Questionnaire Sessions
Pictorial Quizzes	Videotape Symposiums
Syllabuses	Audio-Visual Aids
Meet the Faculty Sessions	

Registration: Entire Course (August 17-30) $750 (before 5/31)
$800 (after 5/31)
Week I (August 17-23) $550
Week II (August 25-30) $550

Includes tuition, printed materials, use of audiovisual aids, library loan of T.V., tapes, cassette tapes and set of slides.

For registration and information write to:
J. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101 Telephone: (305)547-6063

Physicians' Confidential Assistance





Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 337
- ☐ DEAN'S MESSAGE, 338
- ☐ ENCORES!, 339
- ☐ CORRECTION, 343

NOTES & NEWS

1986 Annual Meeting Scientific Program begins to take shape

Specialty groups are submitting their topics and speakers for the 1986 FMA Annual Meeting Scientific Program. According to Pierre J. Bouis Jr., M.D., Chairman, FMA Council on Scientific Activities, each specialty group has been requested to complete program plans by April 15th. Once again AMA Category I credit will be offered and tentative plans are underway to offer credits in risk management which has been mandated by the Department of Professional Regulation for relicensure. In upcoming issues of *JFMA*, a section will be devoted to announcements about scientific programs and other attractions. Make plans now to attend the 112th meeting of the Florida Medical Association.

An NIH consensus development conference on the impact of routine HTLV-III antibody testing on public health

A Consensus Development Conference on the Impact of Routine HTLV-III Antibody Testing on Public Health will be held at the National Institutes of Health (NIH), Bethesda, Maryland, July 7-9, 1986.

Discussion will center on questions concerning experience with routine HTLV-III antibody testing and its impact on the public health of the nation.

The consensus conference will bring together biomedical investigators, blood bank specialists, clinicians, consumers, and representatives of public interest groups. Following two days of presentation by medical experts and discussion by the audience, a Consensus Panel will weigh the scientific evidence and formulate a draft statement in response to several key questions:

- What tests are currently being used? What are their performance characteristics? How should these tests be used?
- What impact has testing had on transfusion medicine?
- What constitutes a positive test? How should a positive HTLV-III antibody test result be interpreted?
- How should positive test results be handled?
- What are the psychosocial ramifications for blood donors of knowledge of a positive test result?
- What research directions should be pursued?

On the final day of the meeting, the Consensus Panel Chairman will read the draft statement before the conference audience and invite comments and questions.

To register to attend the conference, contact Ms. Barbara McChesney, Prospect Associates, 2115 East Jefferson Street, Suite 401, Rockville, Maryland 20852, telephone (301) 468-6555.

Miami Children's Hospital creates Hall of Fame

Miami Children's Hospital has announced creation of an internatinal pediatrics Hall of Fame to honor members of the medical profession and lay persons who have made significant contributions to the health and happiness of children.

Albert H. Nahmad, chairman of the Miami Children's Hospital Foundation, said Jonas Salk, M.D., will be inducted into the Hall of Fame in a special category as the first Mary Ann Knight Memorial honoree. A lay person soon to be named will be similarly honored.

The award has been established in memory of the late Mrs. James L. Knight, a longtime supporter and active leader in behalf of the Crippled Children's Society and other children's health care causes. Mrs. Knight and her husband last July established an endowment for basic and clinical pediatric research at Miami Children's Hospital.

Selection of Salk as an honoree carries particular significance since the hospital originally was founded as a polio care facility. His creation of polio vaccine enabled Miami Children's (then Variety Children's) Hospital to broaden its scope and become a general pediatric care facility.

Salk and the lay individual, selected by the Foundation, and two other doctors and/or laymen, chosen through an international balloting process, will be

honored at a glittering installation ceremony when the hospital's $50 million expansion project is completed and dedicated October 24, 1986.

Nahmad said thousands of ballots will be mailed to initiate the process of selecting the other two persons who will be honored.

The ballots will go to members of the American Academy of Pediatrics and other pediatric societies throughout the world, and to medical writers and editors and medical school faculty members, both nationally and internationally. They will ask for selections of:

> ". . . a member of the medical profession, living or dead, who has demonstrated outstanding aptitude or accomplishments in the field of child health care, or who has accomplished exemplary results in basic or clinical pediatric research."

> ". . . a member of the general public, living or dead, who has demonstrated outstanding leadership, concern and caring that have resulted in making the world a healthier, brighter, happier place for children."

Nahmad said both ballot categories will carry a "seed list" of names to illustrated the types of individuals the Foundation has in mind for the Hall of Fame. The ballots also will encourage write-in of other nominations, and provide room for a summary of the individuals's achievements.

The medical ballot, for instance, lists Allan Roy Dafoe, M.D., the Canadian country doctor who delivered and subsequently cared for the Dionne quintuplets in 1934, and Helen Taussig, M.D., who although not a surgeon, created the procedure for heart surgery on "blue babies."

Nahmad said Hall of Fame ceremonies will be a centerpiece of the Miami Children's Hospital dedication program. Additional details will be announced as the Foundation continues planning for the event.

Founded as Variety Children's Hospital in 1950, Miami Children's has gained international fame for its care and treatment of children from around the world, and for its leadership in pediatric education and research programs. It is estimated that within the next five years some 300,000 children will be treated as inpatients, or cared for at one of the hospital's numerous outpatient clinics.

DEAN'S MESSAGE

Editor's note: The deans of Florida's three medical schools were asked to appoint a medical student to submit an article to run in the Dean's Message section of *The Journal.* This month's medical student is David Campbell from the University of Florida.

Student medical involvement essential to organized medicine

Since AMA membership was opened to medical students in 1972, the number of medical student members has grown to approximately 32,000 (nearly half of the enrolled medical students in the U.S. in 1985). Medical student involvement and acceptance within the association has grown to include representation on six councils of the AMA, student representation in the House of Delegates of the AMA, and a non-voting member on the Board of Governors of the AMA. In each of these capacities the students have been well received and have served the AMA well.

The Medical Student Section of the AMA meets preceeding each annual and interim meeting of the AMA House. At these meetings, students represent their medical schools in the discussion of issues and reports, the selection of their governing council, and the selection of other MSS representatives. At each meeting student representatives also consider legislation proposed by individuals or state sections. This legislation may be proposed as a bill directly to the AMA House or may be considered internally. The structures and functions of the Medical Student Section closely parallel those of the parent, AMA. Members of the Medical Student Section often continue their active participation in organized medicine at the local, state and national level following graduation.

Each year, the AMA, component state and local societies seek to recruit new members from the 40% of eligible physicians who have chosen not to participate. Although aggressive membership recruitment can have some effect, the overall percentage of participating physicians has not changed appreciably. Membership development may be a means by which we can increase the degree of participation. Early involvement in organized medicine can breed interest and enthusiasm for continued involvement throughout a medical career.

The concept of learning by participating is central to medical education. During the medical school and post-graduate training years, the theory of supervised progressive responsibility is stressed. As one demonstrates competence, other duties and responsibilities are added in the clinical setting. This system also exposes the training physician to a hierarchy of teacher/supervisors who serve as role models. In such exposure we build on our own collective experience.

So too, I believe, we can develop good members as well as future leaders for organized medicine. Through the active participation, under the watchful eye of the experienced participant in organized medicine, students and junior physicians can "learn the ropes." Through this active, early participation I

believe we can develop a broader membership base, more knowledgable, younger participants in the association. I see this potential membership base as a valuable resource which, when tapped, has proven valuable to other associations.

In addition to the important task of recognizing a Medical Student Section in Florida (a process which is well underway) I would ask that the local societies and state orgnization consider students as a resource. I would further encourage medical students to consider involvement in organized medicine as a learning experience integral to a complete education. In the rapidly changing environment in which we practice or will practice medicine, a broad based membership of well informed physicians is invaluable. Development of student members may help to provide well versed physicians capable of addressing the issues important to health care in their communities. In addition, it may provide an understanding of how their societies and associations may contribute to policy making, legislation, representation and health care delivery.

The exposure I have had with the AMA, the Medical Student Section, and in the state and local society has contributed to my development as a student and future physician. Speaking for all Florida medical students who have been afforded similar opportunities, thank you. We look forward to further active involvement in the activities of associations at all levels.

David A. Campbell, MS 4
Gainesville

ENCORES!

Lawyers don't have a moral leg to stand on in insurance crisis

To expect the American Academy of Trial Lawyers to tell the truth about the insurance crisis is as foolish as expecting chastity to be the next fad to sweep through Hollywood.

I am not especially fond of the insurance industry, but trial lawyers trying to pin the blame for skyrocketing liability rates on that industry is simply a case of their trying to protect their own gold mine. The fault lies with the trial lawyers. Period. The answer lies in putting a cap on payouts and a damper on litigation in general.

The lawyers have trotted out all their clever lawyer tricks to obscure truth, but it is very easy to understand if you examine the basic principle on which the insurance business operates.

For insurance to work, the company must be able to predict with reasonable certainty the frequency of claims and their amounts. When they can do that, they can compute how much reserves need to be set aside to pay the claims and arrive at a premium rate that will provide the reserves, provide for their costs and something extra for investment.

This is the way the insurance business has operated from day one. It is the only way it can operate. What the lawyers and the new litigation industry have done is make this impossible.

For example, in the past an insurance company could study the history of, say, day-care centers. They would see that as a class, day-care centers produced a certain number of claims with an average payout of so many bucks per claim. Virtually all of the claims were within a certain range. If you know that you can expect 50 claims and that they would average $4,000 each, then it is fairly easy to compute a premium that would be reasonable and sufficient to cover probable claims.

Suppose, however, you have to compute the rates on this basis: Based on the past, I can expect an average of 50 claims and 49 of them will average $4,000 each but one of them will be for $3 million. You now have no choice but to base your premium on the probability that you will have to pay out at least one claim of $3 million. As soon as you include enough money in the premium to cover that huge future payout, the rates become unaffordable.

That is precisely what has happened. When lawyers talk about most claims being relatively small, they are misleading you — cleverly. It is not the average claim that messes up the system; it is the one exorbitant claim.

Suppose life insurance had to be sold with an open-ended payout. Instead of buying a $10,000 life insurance policy, you would just buy a policy. At your death, a jury would decide if your survivors received $10,000 or $10 million. The company would have no choice but to set aside reserves for a possible $10 million payout and the result would be that life insurance would be unaffordable. It would not matter if 99 juries voted only $10,000. As long as at least one voted the $10 million, you would have to base the premium cost on that eventuality.

The lawyers have no moral leg to stand on. There is no reason why a lawyer, who is just a hired arguer, should get rich on somebody else's misfortune. The argument that without the contingency fee, which is a third to a half of the award, poor people could not pursue justice is just an indictment of the lawyer's greed. What lawyers are saying is that we are so high priced that the average guy cannot afford us and we have, through our closed shop, the Bar, made darn sure that neither Legal Aid nor the Legal Services Corp. can touch this lucrative business of personal-injury suits.

I will put this challenge to the American Academy of Trial Lawyer: Put up or shut up. If your interest is really in justice, then allow the Legal Ser-

vices Corp. and Legal Aid lawyers to pursue personal-injury suits on a pro-bono basis.

Excuse me while I roll around on the floor and laugh.

Charley Reese
Orlando

Reprinted with permission from the *Orlando Sentinel*, March 31, 1986.

Doctors and stress: is there really a problem?

Complaining about one's job is an activity enjoyed by all — regardless of nationality, race, and sex or economic, cultural, and educational status — except physicians. Within our profession there is a reluctance to discuss the stresses of medical practice and, worse yet, an unwillingness even to acknowledge their existence. The "conspiracy of silence" isolates physicians who are troubled by aspects of their work and makes it difficult for maladapted and impaired physicians to seek nonjudgmental advice and counseling.

The findings of surveys and descriptive studies indicate that professional dissatisfaction in medicine may be greater than is generally admitted. In a Louis Harris poll of 1,430 practitioners, 50% said they would not recommend medicine as a career as highly as they would have 10 years earlier. Loss of autonomy, loss of personal satisfaction, and excessive personal demands were the prominent reasons cited.

On a more personal level, we can assess our own attitudes by answering the following questions:

Does your job control your life or do you control your job?

Would you like your child to go to medical school?

Do you feel trapped in a "role" instead of feeling that you are doing a job?

Do you have trouble joining nonmedical groups as a participant (not as "a doctor")?

Does your personal life (spouse, children, community, obligations) get in the way of getting your job done?

What would you like to be doing 10 years from now?

Do you make enough money?

The answer to the question about what you would like to be doing 10 years from now should be, "What I am doing now;" many physicians, however, have trouble giving that answer. Income worries among physicians are common and are often markers of professional and personal discontent. Nearly all physicians, residents excepted, can earn an excellent income; those who chronically worry about their income often have chosen a career in medicine for the "wrong" reasons or have personality characterstics that fit poorly with their profession.

The practice of medicine has, to some degree, many of the characteristics that define a stressful job:

- Ultimate responsibility for the process and the outcome of one's work (being "the boss")
- Open-ended and indefinite job responsibilities in terms of time requirements and knowledge expectations
- Intrusion of emotions and cultural codes into work
- "Role fatigue" — you "are" what you do
- Uncertainty of outcome of work
- Confusing, ambivalent relationships with clients (respect or fear, respect or suspicion)
- Over- or underrecognition for one's work
- Sensory discomfort (noise, smells, temperature)
- Physical discomfort and danger
- Being required to work with difficult persons (those who are hostile, fearful, angry, deceitful, irrational)
- Job insecurity

Job insecurity, sensory discomfort (bad smells), and physical danger (TB, hepatitis) are not serious concerns for most of us, and medicine has, of course, many positive characteristics that make it a highly desirable occupation and that balance out some of the negative ones. Nevertheless, we must not lose sight of the difficult aspects of the job that can impair our ability to do our important work and to enjoy it. One way to examine the stresses of medical practice objectively is to categorize them.

Intrinsic stresses • Some stresses are unavoidable because they are intrinsic to the job: working with uncomfortable and fearful patients, for example, or with patients whose antisocial behavior has been "medicalized" into illnesses and diseases; bearing bad news or inflicting pain through tests or treatment even though we picture ourselves as striving to relieve pain: dealing with the ambivalences of the patient-physician relationship (e.g., a patient's simultaneous desire to be taken care of and anger at feeling helpless).

Societal stresses • Rapid changes in health care policy and economics have created conflicts among patients, physicians, hospitals, businesses, and government and have focused national attention on physicians' behavior. Yet many of the problems physicians are blamed for, such as runaway medical costs, are in fact related to societal decisions to spend unlimited amounts of money on health care rather than face honestly the ethical and economic problems of

rationing care for the terminally ill, the elderly, the poor, and other heavy consumers of medical care.

Overrecognition — elaborate praise or exuberant gratitude — or earning more income for one's work than one believes is fair is just as stressful as underrecognition — e.g., taking the time and energy to assess and counsel an immature and unappreciative somatizing patient with anxiety-related complaints.

Role fatigue (the unwillingness or inability to drop the doctor's role for that of the neighbor, scoutmaster, or PTA member) is a common problem that is caused by the unwillingness of patients to let doctors be ordinary people after office hours — or of doctors to be treated as ordinary persons.

Business and legal stresses • Business and legal stresses are, to some degree, encountered by anyone who owns a small business. There is in medicine, however, a profound conflict between the ordinary profit motive and our universally professed altruism that is not found in most professions. Even the simple setting of a price for medical service is something most of us feel uncomfortable doing. Ironically, a "big sale" in the business world, one that would bring recognition and financial reward to a businessman, is equivalent to a catastrophic illness in medicine because the physician's reimbursement is generally related to the severity of the patient's illness.

Physicians are not trained in business skills and react to the accumulating paperwork of modern medical practice with universal annoyance and anger. Fear of malpractice suits has become a nearly obsessive concern to physicians that influences their behavior out or proportion to the actual economic impact of such suits.

Personal stresses • Physicians are not, of course, just passive victims of stress; our personal qualities and past experiences strongly influence how we respond to the inevitable stresses of medical practice. Some of the characteristics and experiences that have been hypothesized or demonstrated to predispose physicians to burnout, unhappiness, and impairment are type A behaviors, e.g., impatience, competitiveness, aggressiveness, achievement orientation: other factors are poor self-esteem, immaturity, and choice of medicine as a career for the wrong reasons.

Type A behaviors and competitive skills are helpful in gaining admission to, and succeeding in, medical school, but nonproductive, exaggerated type A characteristics — preoccupation with achievement and income, easily aroused hostility, impatience — seem to carry a high risk of burnout and professional discontent.

The decision to study medicine is rarely a truly informed or mature one; it often derives from an internalized or subconscious wish to please an important person, usually a parent. Altruism and scientific interests, contrary to what nearly all pre-med students say, are not the reasons they endure premedical and medical training. It is doubtful that those pale motivations sustain them through 11 to 16 years of hard work in premedical, medical, and graduate training. Other observers have speculated that the desire for self-mastery, the need for self-healing and security, and the "need to be needed" motivate and sustain the aspiring physician.

Ideally, the selection of students for medical school and the training of residents should take into account the realities of their future work and should prepare them to deal productively with its stresses. In the process of selection, however, the emphasis is on scholastic achievements and scientific aptitude and less on interpersonal skills and personal qualities. As repeatedly demonstrated, students who have high grades in premedical science studies do well in medical school. But the actual practice of medicine, especially primary care medicine, is so unlike the study of medicine that we should not assume that the same cognitive skills that lead to high grades will also lead to personal happiness and high-quality medical care.

Interpersonal skills are important to patients. Because medical practice consists to a large degree of treating illnesses that are, at some level, psychological in nature, the physician who lacks interst and aptitude for dealing with psychosocial problems and takes little pleasure in addressing them will probably be a discontented and, possibly, an inferior physician. Noncognitive skills and beneficial personal qualities for physicians, such as maturity, social competence, and interpersonal sensitivity, are difficult to teach and measure. We are not yet willing to rely on assessments of personal qualities and psychometric testing, as we depend on grade point averages and scholastic aptitude tests, when we choose and train future physicians.

We should not be surprised, however, when a resident expresses amazement and anger at the chronic noncompliance and self-destructiveness of patients he must work with in the clinic or when a practitioner's patients complain that he is not interested in their problems, only their diseases. Both physicians are using their well-documented cognitive skills and responding to erroneous expectations created by their training in academic medical centers.

In addition, medical schools and training programs have been accused of setting physicians up for future difficulties with the stress of medical practice by adding to the personal problems that students and residents bring to medicine and by taking away the time and energy that the process of maturation requires. To become a mature adult, one must develop an ego and sexual identity, establish independence from parents, acquire a capacity for intimacy, and learn how to be a contributing member of the community; those important aspects of maturation,

however, tend to be squeezed out by the single-minded, intense pressure to develop a vocational identity. Self-protection by distancing oneself from patients' problems, denial and discounting of troublesome inner conflicts, and depression are some of the other commonly observed results of the pressures of medical education and training.

We have, I believe, the components of a serious problem for many medical practitioners: a stressful job that has been selected often for the wrong personal reasons and by some who may be ill suited to it. The education and training of physicians are gratuitously stressful and teach residents short-term adaptive behaviors that are, in the long run, maladaptive.

Courageous but logical societal and educational changes could help students and residents choose a career in medicine for appropriate, psychologically healthy reasons, develop the interpersonal interests and aptitudes that permit them to enjoy and excel at medical practice, and eliminate the hazing aspects of residency training that lead to self-protection rather than to empathy and openness.

Personal options • At the professional level, physicians who are burned out or discontented face two sets of options: negative ones, e.g.,

- Avoidance — look for a new practice, specialty, job
- Retreat to the "quiet life"
- Find a new spouse who will make you happy
- Retreat to drugs, alcohol

and positive options, e.g.,

- Reverse the work obsession
- Allow yourself to enjoy your job
- Redefine your "self" from within, independent of your profession
- Commit yourself to personal health
- Take responsibility for your own happiness

Ironically, the negative options seem to be chosen more often. By externalizing blame on circumstances or other persons (often one's spouse), apparently dramatic "solutions" — moving, changing jobs, changing one's spouse — can look attractive. Like the alcoholic's ex-wife who chooses another alcoholic for a husband, however, we tend to carry our problems with us. A retreat to the quiet life in a small town is more likely to move one's career discontents to that small town than to resolve them. Likewise, the physician who thinks that an unhappy home life is making his job unpleasant is missing the obvious; his unhappiness is affecting both his marriage and work, and changing spouses won't make medicine more enjoyable! Retreating into the use of drugs and alcohol is a more obvious maladaptation — one that characterizes the impaired rather than the unhappy physician.

Positive options seem to be much harder to choose. They require us to recognize that practicing medicine is what we "do," not what we "are." We must learn to draw clear boundaries between work and leisure and to reverse our work obsessions. We need to allow ourselves to enjoy the innumerable pleasures of our job and to use those pleasures to balance its intrinsic, inevitable difficulties. We must recognize that medicine is to a large degree the skillful exercise of interpersonal talents and work on those abilities just as conscientiously as we work on acquiring knowledge. A commitment to personal health (following the advice we give to our patients!) should emphasize reasonable work hours, adequate time for recreation, exercise, a good diet, and good medical care.

Those of us who are not emotionally strong enough to assume that type of responsibility for enjoying our jobs and for rediscovering the importance of our personal lives outside medicine need help — help to redefine the self within us that is independent of our job and our medical achievements.

Jack D. McCue, M.D.
Winston-Salem, N.C.

Reprinted with permission from *Hospital Practice* March 30, 1986, pg. 7-16.

Respiratory hazards of anti-static clothes softeners

Anti-static clothes softeners are now used extensively in homes. My interest in their potential respiratory hazards was triggered by Case #1. This observant young woman pointed out the unequivocal relationship between her presumed nasal-bronchial "allergies" and the use of Bounce R. This fabric-softening preparation contains non-ionic and cationic types of softening agents (dialkyldimethylammonium methyl sulfate and a fatty acid ester of polyhydric alcohol), and a perfume. The non-woven rayon cloth is placed with clothes in a dryer.

I subsequently encountered five other patients in whom rhinitis, sinusitis, cough or wheezing were precipitated or aggravated by this and comparable products. Relief promptly occurred after ceasing such exposure. Several of these patients communicated their experiences to friends, who in turn related comparable reactions either in themselves or other acquaintances.

The provoking of exacerbations by re-exposure to these products was considered. In view of the sustained severe respiratory distress reported by others

(see Comment), however, I did not feel justified in recommending such challenge after a clinical remission.

Case 1 ● A 34-year-old white female had been troubled with unexplained nasal and sinus complaints, wheezing, and repeated coughing. These disorders persisted in spite of allergic precautions and a host of medications, including corticosteroids.

During a two-week vacation in Colorado, she had no respiratory distress. Its recurrence on her return was attributed to household allergens or local pollination.

Shortly thereafter, these symptoms spontaneously abated. The patient chanced to comment to her housekeeper on the abscence of the Bounce odor in the clothes. She was informed that the supply had been exhausted during this period. As soon as Bounce was added, her symptoms recurred.

Case 2 ● A 68-year-old female experienced recurrent cough and upper respiratory symptoms. . .but only after retiring. She had not evidenced previous allergies or congestive failure, and did not smoke. When questioned about Bounce, she indicated that her symptoms began shortly after covering herself with sheets so treated. They disappeared shortly after it was discontinued.

Case 3 ● A 58-year-old male had been troubled with an unexplained recurrent cough. On learning of a possible relationship to exposure to Bounce, he volunteered that his cough was precipitated "every time I do the laundry." It abated after stopping this product.

Comment ● The ever-lengthening list of potential respiratory irritants in the environment forms the basis for much of the current interest in "clinical ecology." Many remain unsuspected until alert patients suspect such an association. This was the case, for example, with fungal contamination of automobile air conditioners.

The literature contains multiple reports of respiratory symptoms and cutaneous irritation attributable to Bounce.

- Mauceri and Rosan[1] noted the exacerbation of bronchial asthma in three patients having bronchial asthma following exposure to linens so treated.
- Oster[2] reported the precipitation of rhinitis, wheezing and cough in his wife after treatment of linens with a sample of this product. She had no past or family history of allergies.
- Sheard[3] described four cases of acute contact dermatitis due to Bounce. The onset coincided with first-time use.
- Hazelrigg and Hargett[4] encountered both severe dermatitis (three patients) and marked respiratory distress (two patients) after their exposure to Bounce.
- Huldin[5] reported five patients with contact dermatitis and two with "extrinsic asthma" following exposure to clothing treated with Bounce.
- Weaner and Herrmann,[6] representatives of the manufacturer, investigated 300 (!) persons alleged to have adverse skin reactions to Bounce. They inferred an "anecdotal association of adverse reactions to use of the product" in most instances.

Public exposure to Bounce is widespread. Dr. James E. Weaver, a representative of Proctor & Gamble, hinted at its enormity even in 1977: "Since Proctor & Gamble began selling Bounce four years ago, more than 40 million households have safely used over two billion sheets of it."[7]

In view of the widespread use of this product and similar anti-static clothes softeners, attention must be directed to the respiratory and cutaneous complications. Manifestly, such aggravation of existing pulmonary, cardiac and dermatologic disorders poses an imminent public-health hazard.

Summary ● Five patients have been encountered within a two-month period in whom recurrent unexplained upper and lower respiratory symptoms subsided after their cessation of exposure to Bounce.

The widespread use of this anti-static clothes softener and similar products with such potential for severe respiratory and cutaneous reactions warrants prompt evaluation as an imminent public-health hazard.

The assistance of Mr. Louis Brizel in the preparation of this manuscript is greatly appreciated.

H. J. Roberts, M.D., F.C.C.P.
West Palm Beach

References

1. Mauceri, R.S., and Rosan, J.R.: Possible asthmatic reaction to fabric softener. New Engl. J. Med., 294:907, 1976.
2. Oster, M.W.: More on "Bounce" and asthmatic symptoms. New Engl. J. Med. 294:1297, 1976.
3. Sheard, C.: Side effects of Bounce, Arch. Dermatol. 113:376, 1977.
4. Hazelrigg, D.E., and Gargett, I.R.: Side effects of Bounce, Arch. Dermatol. 113:376, 1977.
5. Huldin, D.H.: Side effects of Bounce. Arch. Dermatol. 113:376, 1977.
6. Weaver, J.E., and Herrmann, K.W.: Evaluation of adverse reaction reports for a new laundry product, J. Am. Acad. Dermatol. 4:577-583, 1981.
7. Weaver, J.E.: Side effects of Bounce, Arch. Dermatol. 113:376, 1977.

Reprinted with permission from *The Palm Beach County Medical Society Bulletin*, January, 1986, pg. 24-26.

CORRECTION

The title that appeared with the first Letter and Viewpoint of the March issue, Vol. 73, No. 3, page 179, should have read "Mandatory Malpractice Insurance and Potential Problems of Non-Compliance."



At Tampa General, We Combine the Science of Medicine with the Art of Caring.

That's the way we practice medicine. We call it "The Art of Caring," and it's prescribed for everyone who enters our hospital.

Your lasting impression of Tampa General will be more than just our state-of-the-art equipment. You'll always remember the caring smile and gentle touch that was there when you needed it.

For nearly 60 years, we've been a part of your family. That's why we built our new Patient Towers, so that we'll be able to continue giving you and your family the highest quality health care in the most comfortable surroundings.

This spring, we'll open our nine story twin Patient Towers, providing our community with the most modern medical center in Florida. The sophisticated medical technology that you and your family deserve will be there. And so will the Art of Caring.

When you need some special care, we'll be there.

The Tampa General Hospital

Davis Islands • Tampa, Florida 33606 • (813) 253-0711

Unless you live in a Florida Grove, You can't eat fresher fruit.

We offer the finest, freshest citrus fruit in the world. Our fruit is hand-picked at the exact moment of ripeness, hand-packed, and then shipped — all on the same day!

We ship only the best 1% of an entire crop, insuring that your fruit will be the finest available anywhere.

Give your family and friends the Gift of Health.



For Florida Medical Foundation
Mrs. Gary Wright (Charlotte)
4171 S.E. 38th Street
Ocala, Florida 32671
904-629-2248 or 904-732-4032

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Missing children posters program started

A pilot program begun in February by the FMA Auxiliary and the FMA will show "We Care" by helping Florida physicians to identify missing children.

The program will use posters printed with the names and photographs of missing children believed to be in the state of Florida. Educational seminars to help train physicians to recognize the signs and symptoms of the abducted or exploited child will be held. One seminar was held at the January Leadership Conference in Tampa. Jay Howell, executive director of the National Center for Missing and Exploited Children, spoke at this seminar. He stated that "Contrary to popular belief, missing children are often taken to physicians and hospitals for medical treatment." The National Center is supplying the information about the children and a toll free number for medical treatment." The National Center is supplying the information about the children and toll free number for medical personnel to call if they suspect they are treating a child who has been abducted. "We know that two things happen to missing children," Howell said, "They are enrolled in schools and they get medical treatment."

The FMA and FMA Auxiliary chose this project because this is a serious problem in which physicians can play a key role in identifying children. With the FBI listing about 35,000 missing children, it was felt that this type of program was needed. So far, Florida is the only state to have a program aimed specifically at physicians.

Interest in the Missing Poster Program by the news media has been overwhelming. Four Tampa/St. Petersburg television stations covered the story, as well as three radio stations, the *Tampa Tribune*, the *Sarasota Herald Tribune*, and UPI. Inquiries continue as the program is being implemented. County societies have an excellent opportunity to receive even further good publicity from this program. They are being encouraged to invite the media to meet at a physician's office or hospital where the program can be announced and the news media can get photos of the physician putting up the poster on the bulletin board.

FMA Auxiliary President Mrs. Milton R. Tignor, speaking at the Tampa Seminar, showed that "We Care" when she said, "Our goal with this program is to make physicians more aware of the problem and furnish them with information on how to spot a missing of exploited child and then what to do. Our efforts will be rewarded if only one missing child is found."

If you think you have seen or have information on any of the children on the posters, call toll-free: 1-800-843-5678. For more information, contact the National Center for Missing and Exploited Children, 1835 K St., N.W., Washington, D.C. 20006. Over 200,000 children are officially reported missing each year; you can help.

Mrs. W. Jackson (Elaine) Dickens
FMA Auxiliary Public Relations Chairman
Sarasota

PRACTICES AVAILABLE

ALLERGY — Suburban Philadelphia — Excellent opportunity — Very low price.

ALLERGY — Philadelphia area — Very large practice.

DERMATOLOGY — Connecticut — Strong finances.

FAMILY PRACTICE — Philadelphia and suburbs — Several practices.

INTERNAL MEDICINE — Arizona — Well equipped.

INTERNAL MEDICINE — D.C. Suburb — desirable community.

PEDIATRICS — Northeastern Pa. — Young growing practice.

PEDIATRICS — Colorado — Convenience of a group — Strong finances.

PEDIATRICS — Central New York — Very large practice.

RADIOLOGY — Philadelphia —Large, well established.

SURGERY GENERAL — New Jersey — Attractive practice near New York City.

We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice, contact our Brokerage Division at: Health Care Personnel Consulting, 403 GSB Building, Bala Cynwyd, Pennsylvania 19004.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.,* P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

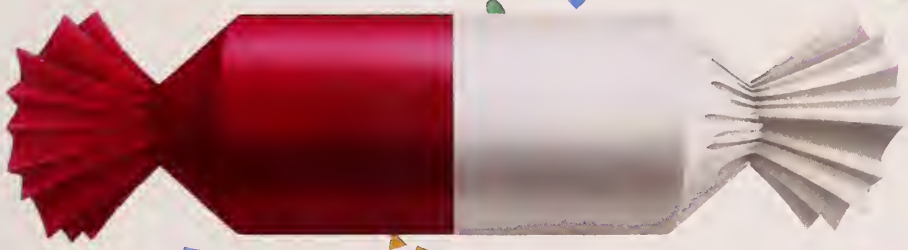
Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

20 YEARS

Thank you for your loyal support



DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

SK&F CO.


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2406

EMPLOYEES APPRECIATE THE PAYROLL SAVINGS PLAN.

JUST ASK THE PEOPLE AT THE BOEING COMPANY.

"My folks gave me a Bond for my birthday every year. Now I can do the same for my kids."
—Vaughn Hale



"It's certainly a painless way to save. The money comes directly out of my paycheck every two weeks."
—Florence Perry



"This is one way I can support my government and save at the same time."
—Douglas Scribner



U.S. Savings Bonds now offer higher variable interest rates *and* a guaranteed return. Your employees will appreciate that. They'll also appreciate your giving them the easiest, surest way to save.

For more information, write to: Steven R. Mead, Executive Director, U.S. Savings Bonds Division, Department of the Treasury, Washington, DC 20226.



U.S. SAVINGS BONDS
Paying Better Than Ever

A public service of this publication.

YOUR NEW LOW DAILY RATES AT AVIS START AT $33.00



Avis features GM cars. Buick Century.

Your association membership means new, uniform low flat rates at Avis. And there's no charge for mileage. Choose from subcompact through full size 4-door car groups:

DAILY RATE	
SUBCOMPACT (Chevrolet Chevette or similar)	$33.00
FULL SIZE 2-DOOR (Buick Century or similar)	$39.00

These uniform low flat rates make it easy to know your rate before you go. To reserve a car, call Avis toll free: ***1-800-331-1212***

Be sure to mention your Avis Worldwide Discount number: **A/A616900.**

AVIS ***WE TRY HARDER.***®

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. Flat rates are nondiscountable and are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. An additional charge per day will apply in certain locations including Newark Airport, NJ; LaGuardia Airport, NY; Kennedy Airport, NY; and all Manhattan locations. Check with Avis for the amount. Rates, discounts and additional charges subject to change without notice. Cars must be returned to rental location or higher daily rate and a one-way service fee will apply. Cars and particular car groups subject to availability. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

© 1985 Avis Rent A Car System, Inc., Avis®

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

MAY

Advanced Cardiac Life Support, May 9-11, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., P.O. Box 18566, Tampa, FL 33679, (813) 251-6911.

Magnetic Resonance Imaging 1986, May 5-9, Hyatt Orlando, Disney World. Contact: Lawrence Muroff, M.D., USF College of Medicine, 12901 N. 30th Street, Tampa, FL 33612 (813) 873-2090.

Peptic Ulcer Disease, May 6, Jess Parrish Memorial Hospital, Titusville. Contact: Frederick H. Dobbs, M.D., Drawer W., Titusville 32781, (305) 268-6140.

New Bugs vs. New Bugs — Update on Infectious Diseases, May 10, West Florida Regional Medical Center, Pensacola. Contact: James Picardi, M.D., 8333 North Davis Highway, Pensacola 32514, (904) 474-8000.

Fractures of the Acetabulum & Pelvis, May 11-18, Paris, France. Contact: Emile Letournel, M.D., 813-974-3322.

Five-day Diabetes Management Course, May 12-36, USF College of Medicine, Tampa. Contact: Anthony Morrison (813) 974-4360.

Current Therapy in Hypertensive Control, dMay 15, Crown Hotel, Inverness. Contact: J.A.D. Callveng, M.D., P.A., 905 N. Citrus Ave., Crystal River 32629. (904) 795-7331.

Pediatrics for the Practitioner, May 16, Bay Harbor Inn, Tampa. Contact: Lewis A. Barness, M.D., 12901 North 30th Street, Tampa 33612, (813) 974-4214.

"Disciplining the Impaired Physician," "Risk Management Seminar" and "Neurology of Golden Years", May 16, 17, and 18, Grenelefe Resort, Haines City. Contact: Richard Garcia, M.D., P.O. Box 927, Lakeland 33802, (813) 682-0543.

Master Approach to Cardiovascular Problems, May 24-26, Contemporary Hotel, Lake Buena Vista. Contact: Augustin Castellanos, M.D., P.O. Box 016960 (D-39), Miami, (305) 549-7124.

JUNE

Medicolegal Issues in Obstetrics, June 2-5 and June 16-18, Marriott Hotel, Orlando. Contact: Robert Knuppel, M.D., USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 251-3748.

Seventh Annual Child Neurology Postgraduate Course, June 9-12, Sonesta Beach Hotel, Key Biscayne. For more information: Oscar Papazian, M.D., 6125 S.W. 31st Street, Miami 33155 (305)666-6511, Ext. 2423.

Physician in Management Seminars I & II, June 9-13, The Antlers Hotel, Colorado Springs. For more info: Sherry Masons, 4830 W. Kennedy Blvd., Suite 648, Tampa 33609, (813) 873-2000.

Florida Suncoast Pediatric Conference 1986, June 14-18, Trade Winds Resort, St. Petersburg. For more information: Gilbert Pitisci, M.D., 2506 West Virginia Ave., Tampa 33607, (813) 870-8720.

Supportive Care of the Cancer Patient, June 20-21, Holiday Inn, Pensacola Beach. Contact: John Bachi, M.D., 1201 W. Moreno Street, Pensacola 32501, (904) 434-4917.

FAFP 37th Annual Scientific Assembly, June 26-29, Marriott's Marco Beach Resort, Marco Island. For more information: Martha Moores, 4057 Carmichael Avenue, Suite 229, Jacksonville 32207, (904) 398-5667.

JULY

Coronary Heart Disease, July 18-19, Dutch American Hotel, Orlando. For more information: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

MRI, CT & NM in Clinical Practice, July 21-25, Grand Hotel, Paris, France. Contact: Lawrence Muroff, M.D., USF College of Medicine, 12901 N. 3oth Street, Tampa 33612, (813) 873-2090.

Imaging Advances in Medicine, July 28-August 1, Churchill Hotel, London, England. Contact: Lawrence Muroff, USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 873-2090.

AUGUST

Second Annual Laser Surgery Training Course, August 12-16, Wyndham Hotel, Orlando. For more information: Patti Devlin, 1414 South Kuhel Avenue, Orlando 32806-2093, (305) 841-5144.

Pediatric-Oriented Advanced Cardiac Life Support, August 22-24, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Strategic and Operational Survival Plans for Office Based Physicians, August 22-24, Orlando Hyatt Hotel, Orlando. For more information: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

A Stitch in Time, August 24-28, Amelia Island Plantation Convention Center, Amelia Island. For more information: Ira M. Dushoff, M.D., 580 W. 8th Street, Jacksonville 32209, (904) 355-0561.

SEPTEMBER

Doppler Echocardiograph Seminar, September 11-13, Innisbrook Resort, Tarpon Springs. Contact: Ann Connelly, R.N., 300 South Hawthorne Road, Winston-Salem, NC 27103.

Aviation Medical Seminar — For Aviation Medical Examiners, September 18-21, Doral Hotel, Miami. Contact: James L. Harris, M.Ed., P.O. Box 25082, Oklahoma City, OK 73125, (405) 686-4881.

OCTOBER

CardioRespiratory Disease, October 1-4, Marriott's Orlando World Center, Orlando. Contact: Patti Devlin — CME Coordinator, Orlando Regional Medical Center, 1414 S. Kuhl Avenue, Orlando 32806-2093, (305) 841-5144.

Fourth Annual Advanced Neuroradiology Seminar, October 9-11, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Fifth Annual Medical Laboratory Immunology Symposium, October 19-22, Holiday Inn Surfside, Clearwater. Contact: Herman Friedman, Ph.D., (813) 974-3281.

Get more exposure for your AMA Category I approved meeting: list it in the The Journal Meeting Section.

Contact:
Mrs. Dawn Gerik
FMA Headquarters
(904) 356-1571.

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name: _____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

FAMILY PRACTICE opportunity: South Miami area. Board eligible or certified preferred. Excellent pay and working conditions. Affiliated with major medical center. Full or part-time. Respond with C.V. to Box C-1306, P.O. Box 2411, Jacksonville, FL 32203.

PRIMARY CARE CENTERS IN FLORIDA, NEW YORK, NEW JERSEY: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full time basis. Positions available in Central and South Florida coastal communities, central and northern New Jersey, and Long Island, New York area. Guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 930 South Harbor City Blvd., Suite 307, Melbourne, FL 32901.

EXCELLENT OPPORTUNITY available for Florida Licensed ophthalmologist to join busy practice in coastal Florida city. Retinal fellowship preferred. Please send curriculum vitae and recent photo to P.O. Box 17125, Jacksonville, FL 32245-7125.

DIAGNOSTIC RADIOLOGIST North Orlando area - private clinic approximately 15 to 20 hours per week. Flexible arrangement. Reply to C-1323, P.O. Box 2411, Jacksonville, FL 32203.

DIAGNOSTIC RADIOLOGIST, Board Certified needed to join rapidly expanding hospital based solo-practice. Must have angiography/special procedures training/experience. Personable, willing to practice hands-on radiology. Large hospital located on the west coast of Florida, well equipped, MRI Pending. Box C-1329, P.O. Box 2411, Jacksonville, Fl. 32203.

OB/GYN — If you are a board certified or finishing resident who might be interested in a rewarding professional practice, give Murphy, N.C. serious consideration. Murphy Medical Center is a six year old, 50 acute care bed facility which serves a seven county population of 100,000+. Located in the foothills of the Smokey Mountains, Murphy offers the advantages of a small-town life-style, with numerous outdoor activities, without the sacrifice of urban advantages. Attractive first year financial guarantee is available. For more information write or call: CEO, Murphy Medical Center, 2002 U. S. Highway 64 East, Murphy, N.C. 28906, (704) 837-8161.

OB-GYN WANTED: To join 14-man multi-specialty group. Must be board certified or board eligible. Competitive salary and excellent fringe benefits. Send CV reply to Medical Arts Clinic, Inc., 301 West Liberty, Farmington, MO 63640, Attention: Ronald G. Stevens, Adminitrator, or call (314) 756-6751.

EMERGENCY PHYSICIAN for hospital E.D. in Central Florida seeing 18,000 patients. Prefer U.S. trained. Direct contract. No agency. Competitive renumeration. 42 hour week. Insurance paid. Three weeks vacation. CME reimbursed. Respond with C.V. to Box C-1328, P.O. Box 2411, Jacksonville, Fl 32203.

FAMILY PHYSICIAN: Board eligible; for West Palm Beach practice. Florida license necessary. Opportunity for future partnership. 305-964-0234.

FAMILY PRACTICE PHYSICIAN — ORLANDO. Family physician for primary care centers serving migrant and indigent families. Good salary and benefits. Equal opportunity. Send C.V. to Gil Walter, P.O. Box 1249, Apopka, FL 32703, or call collect (305) 889-8427.

UROLOGIST needed with Florida license to join large fully equipped clinic in Pasco County the 7th fastest growing county in the United States. Send C.V. P.O. Box 36, New Port Richey, Florida 33552.

ORTHOPEDIC SURGEON needed with Florida license to join large fully equipped clinic serving a rapidly growing West Coast Florida community. Send C.V. P.O. Box 36, New Port Richey, Florida 33552.

CARDIOVASCULAR THORACIC SURGEON with Florida license needed to join large fully equipped Clinic serving a rapidly growing West Coast Community. Send CV to P.O. Box 36, New Port Richey, FL 33552.

INTERNIST with Cardiology and Pulmonary experience needed to join large fully equipped Clinic serving rapidly growing Florida West Coast Community. Must have Florida License. Send CV to P.O. Box 36, New Port Richey, FL 33552.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PHYSICIAN or general internist to join busy internist in the Florida Keys. Flexible association available. University training preferred. Send CV: R. Carraway, M.D., P.O. Box 2008F, Key West, FL 33040.

INTERNIST WANTED: For association with four internists. Southeast coast of Florida. Board qualified. Salary: $50,000, plus a percentage. Early partnership assured. Reply: P.O. Box #812, Lake Worth, Florida 33460.

SOUTH FLORIDA HMO has positions available for Board certified/eligible Internists and Family Practitioners. Excellent salary, benefits, paid malpractice, and attractive scheduling. CV to: Richard Kaine, M.D., 1901 S. Congress Avenue, Suite 410, Boynton Beach, FL 33435 or call (305) 737-6850.

FAMILY PHYSICIAN: family practice physician, Board certified/Board eligible, to join a progressive growing multi-specialty group. Salary and benefits are exceellent and environment is beautiful. Please respond with CV to Dr. Gary R. Silverman, Doctors Clinic, 2300 Fifth Avenue, Vero Beach, FL 32960.

TAMPA, FLORIDA — Excellent opportunity for a Board Certified or Board Eligible family practitioner. Immediately available. Excellent compensation and fringe benefits. The individual should be highly motivated and dedicated to the delivery of quality health care. Private practice setting. Send C.V. to John Q. Stauffer, M.D., 2919 Swann Avenue, Suite 205, Tampa, FL 33609.

PSYCHIATRIST — full-time position open for Board certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient and limited in-patient. Florida license needed. Write or call: A. Mullin, M.D., Mental Health Clinic of Jacksonville, Inc., 2627 Riverside Avenue, Jacksonville, Florida 32204, Phone (904) 384-2364.

OCEAN MEDICAL CENTER (established 1969) 4001 Ocean Drive (A1A) Lauderdale-by-the-Sea, Florida 33308. Serving Ft. Lauderdale Beach, Galt Ocean Mile and vicinity (30,000 pop.). Mature specialists wanted for rental suites (individual practices) July 1986 — must have Florida license. Need for: ENT, Dermatology, Orthopedics, Neurology, Rheumatology, Plastic Surgery and Radiology. Write Administrator or call collect: (305) 776-5807.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in- house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4204.

MEDICAL DIRECTOR — HMO. Full time salaried position, to provide leadership for QA and Medical policies. Florida licensed, BC/BE Internal Medicine or General Practice. Location — West Central Gulf coast. Send C.V. to: Administrator, 7626 Massachusetts Ave., New Port Richey, FL 33552.

TWO POSITIONS AVAILABLE immediately. Excellent opportunity for Family practitioner/Internist. BC/BE in west coast Florida. Im mediate appointment with excellent salary, benefits and profit sharing. Reply in con fidence to Oneco Medical Center, Attn. B.A. Hooli, P.O. Box 1486, Oneco, FL 34264.

Situations Wanted

INTERNIST completing subspecialty fellowship in pulmonary medicine July 1, 1986 seeking academic and clinical practice group for affiliation. CV, recommendations, etc. on request. Please respond to Warren S. Goff, D.O., 21631 Jacksonville Road, Farmington Hills, Mi. 48027, phone 313-474-4414.

PHYSICIAN ASSISTANT: Board certified, 36, 7 years experience in family practice and acute care. Personable, enthusiastic, motivated. Practice management skills. Guaranteed to build practice, increase net income. $175K/yr. ave. gross. Reg. salary pkg. with equity sharing. Prefer coastal S.E. U.S., private sec tor. Robert White, PA-C, 4214 Redwood Ave., Jacksonville, FL 32207, (904) 731-9079.

BOARD CERTIFIED INTERNIST: Young, well trained — seeks partnership/group practice in Tampa Bay area. Please reply: Box C-1330, P.O. Box 2411, Jacksonville, Florida 32203.

LOCUM-TENENS: RADIOLOGIST, Board Certified, university trained with academic background, age 47, experienced in most modalities, will consider office and/or hospital-based practice. Please write C-1311, P.O. Box 2411, Jacksonville, FL 32203.

PULMONOLOGIST: Will complete fellowship at the University of Kentucky in July of 1986. Looking to locate in Florida. Licensed in Texas and Kentucky. Contact: Jerry Sampson, M.D., 2080 Regency, Lexington, KY 40503, (606) 277-3711.

FAMILY PRACTICE PHYSICIAN: Board Certified, Florida licensed; extensive academic and practice experience; seeking associa tion with solo or group practitioners or academic position full or part time; available July 1986; West Palm Beach or vicinity only! Edward H. Davis, M.D., 315 Beach 143 Street, Neponsit, NY 11694.

FMG, ABIM, Gastroenterologist - University trained. Seeking practice opportunity in solo or group in Florida and South East United States, starting July 1986. Would consider other locations. C-1326, P.O. Box 2411, Jacksonville, FL 32203.

LOCUM TENENS: Board Certified anesthesiologist: 30+ years experience. Florida license, malpractice coverage. Call (904) 799-3104 or (904) 596-0729.

WELL TRAINED BOARD certified female internist — seeks to buy established practice, internal medicine or family practice, in Florida starting June '86. C-1332, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

RETIREMENT MINDED OB-GYN in north Florida look ing for partner in practice grossing 400,000 t. Partnership immediately with transfer of practice in two years. C-1316, P.O. Box 2411, Jacksonville, FL 32203.

FOR SALE: FLORIDA OPHTHALMOLOGY Practice in Tampa. High surgical volume. Excellent Terms. Available immediately. Phone 813-862-6210 or write 14003 Lakeshore Blvd., Hudson, Florida 33567. Attn: Karen Crandall.

FLORIDA WEST COAST: Splendidly located, freestanding clinic for family practice or walk-in. Laboratory and x-ray. Rapidly expanding community. Nearby accredited hospital. Annual gross over 400,000.00. C-1321, P.O. Box 2411, Jacksonville, FL 32203.

BEAUTIFUL LAKELAND, FL: Solo family practice and 1,876 square foot office, furnishings and equipment. Four examining rooms, x-ray, lab, EKG, efficiency apart ment. Seven hundred bed open staff hospital. Phone 1-813-646-2734.

PSYCHIATRIST with psychoanalytic orientation and forensic subspecialty seeks associate, new or established M.D., board certified or eligible, with FL license to join and/or buy established 13 year psychiatric practice, located in metropolitan Tampa Bay area. Willing to consider creative options with view toward retirement. Terms flexible, negotiable. Dr. P. Callahan, P.O.B. 1686, Largo, FL 34294. (813) 584-4275 24 hrs.

FAMILY PRACTICE for sale in beautiful Jupiter area. Condo office, equipped, nice. Ideal for F.P. or I.M. Good in come. Must retire, health reasons. Two good hospitals, require BE or BC. (305) 747-0279, after 7 p.m. please.

FOR SALE: OB/GYN prac tice. Physician retiring. Last year grossed $170,000, which could be doubled. Office located next to hospital. All modern equipment. N.C. malpractice insurance is $14,000. Call afternoons (919) 892-4131.

PEDIATRIC PRACTICE: (BCBE) in rapid growth area of Central Florida. Busy, well established, fully equipped practice. Terms negotiable, will introduce. Fla. license. C-1325, P.O. Box 2411, Jacksonville, FL 32203.

INTERNAL MEDICINE/CARDIOVASCULAR DISEASES: Growing solo practice in prestigious Kendall area of Miami. Next to 400 bed hospital with open heart program. Much equipment possibly available. Trained staff and pleasant patients will make transition easy. Grosses over $200,000/year. Inquiries: Doctor, Box 365, Miami, FL 33243-0365.

PRACTICE FOR SALE: Excellent opportunity for GP in Miami. 15 years established. Centric location near hospitals. Fully equipped. 9 to 5: (305) 642-4366, evenings: (305) 531-3684.

NORTH CENTRAL FLORIDA: University and medical center community. Solo pediatric practice. Will phase out if desired. Excellent hospital nearby. C-1305, P.O. Box 2411, Jacksonville, Florida 32203.

UROLOGY PRACTICE: Well-established, fully equipped, located on southeast coast in attractive office park near two excellent hospitals. Will introduce and assist in transfering patient care. Reasonably priced. Mr. Harold Kwart, Professional Consultant (305) 751-0580.

PRIVATE PRACTICE Available, Florida's Space Coast. Same location for 28 years across from Ocean. Fully equipped office, lab X-ray & EKG. Hospital staff available. Retiring will introduce. High income potential. Contact: L.R. Wells, M.D., 2210 S. Atlantic Ave., Cocoa Beach, FL 32931.

FOR SALE: General internal medicine practice. Florida Gulf Coast. Net income over 100K. Price of $17,000 includes office furniture and some equipment. Available June, 1986. C-1331, P.O. Box 2411, Jacksonville, FL 32203.

Real Estate

RETIRING BOARD CERTIFIED OB-GYN selling or leasing completely equipped office, capacity for 2 or more Ob-Gyns. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL 33146, (305) 667-3677.

OFFICE FOR RENT. 3200 Square feet in medical building with five other specialists. Excellent location. Call (305) 295-4644.

CAYMAN ISLANDS — modern 2 bedroom beach house on Cayman Brac. Superb snorkelling and scuba. Quiet outisland setting. Rental $350.00 per week. Dr. R. Lament, 2187 West 4th Avenue, Vancouver B.C. Canada (604) 733-5722.

FUTURE OFFICE SPACE: Available June 1986. Prime location north St. Petersburg. Will build to suit. Free standing professional building. George Stovall, (813)896-5371.

PHYSICIAN OWNER MUST SELL new fully furnished ocean front condo at Seawatch (Vilano Beach). On ocean, pool, tennis, covered parking. 2 bedroom, 2 bath. Below market. Phone (305) 278-1063.

SPRING HILL, FL - 2300 square foot professional of fice space in modern new prestigous building with prime exposure. For sale or lease - owner will finance. (904) 596-4162 weekdays.

HANDSOME SECOND INCOME: Franchise starting in Florida to physicians and dentist only; do not miss this opportunity call Bob Richardson (305) 977-9322.

TAMPA, FL — 945 Sq. Ft. medical office condominium unit for sale or rent next door to hospital. OB Equipment and furnishings available. Reasonable. Phone 813-962-8514.

MY FREE-STANDING optometric office of 24 years is for lease, 2700 squre feet, ½ mile to Memorial Hospital, personal offstreet parking, 6817 Beach Blvd., R. H. Miller, O.D., 725-5076.

AMELIA ISLAND. Oceanfront building lots. Single Family or Duplex. Must sell. Owner Financing. Asking $79,000. Charles Burns, 1461 Avondale Ave., Jacksonville, FL 32205, 904 389-7807 evenings.

COLORADO - Picturesque mountain ranch home for rent. Comfortable any season. All outdoor activities. Adjacent wilderness area. Also 3 lovely building sites available. Brochure. Thomas Beach, M.D., (904) 387-7300.

INVEST IN THE FUTURE: Invest in Florida. Let us list or locate for you with confidence and personal attention. Com mercial - Acreage - Farms. Greg Martin Real Estate, Inc., P.O. Box 2445, Belleview, FL 32620. (904) 245-9113.

FOR LEASE: This beautiful 1,000 sq. ft. of office space is located on the ground floor at two very busy intersections in a Condo area. Broward County. Fantastic exposure. Low rent. Will be available in the Spring 1986. Phone 1-800-533-5564.

SHARE MEDICAL-SURGICAL office 5½ days, 1500 E. Hillsboro Blvd., Deerfield Beach, FL 33441. 3 exam rooms, lab, and business office. Patrick E. Callaghan, M.D. (305) 428-2420.

NURSING HOMES and adult congregate living facilities — limited partnerships. Earn over 16/. Life Care Retirement Facilities, Inc. Contact: Milton — (305) 891-0594 after 7:00 p.m.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, promptservice. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

MEDICAL PRACTICE: planning, development, assessment, physician recruitment, marketing and sales. Professional. Confidential. Over 12 years Florida experience. Lic. R.E. Broker. Dr. P. Callahan and Associates, P.O.B. 1686, Largo, FL 34294. (813) 584-4275.

ATTENTION PHYSICIANS in South Florida who have nonambulatory patients in nursing homes or private homes. We are a portable x-ray service licensed and certified in South Florida. All your radiographs are interpreted by a Board Certified Radiologist with a written report sent promptly to your office. Medicare accepted. Reliable Radiographic Services 755-3349.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and reconditioned Holter-Stress-Echo-EKG and other medical Electronic Instruments. Contact Ed Bentolila, P.O. Box 8676, Coral Springs, FL f33065, (305) 972-4600.

Meetings

BIOFEEDBACK THERAPIST TRAINING PROGRAM - Six day program (2-3 day weekends) to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. CEU's Available. Jan. 17-19 & Jan. 24-26, or March 1-3 & March 15-17, or May 16-18 & May 30-June 1, or July 11-13 & July 25-27, 1986. For brochure con tact: Hartje Stress Clinic, 2429 University Blvd., West., Jacksonville, FL 32217. (904) 737-5821.

1986 CME CRUISE/CONFERENCES ON selected medical topics - Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-12 days yearround. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) & AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican, Mediterranean, Alaskan cruises. Excellent group fares on finest ships. Registration limited. Pre- scheduled in compliance with present IRS requirements. In formation: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

MAY 1-4, FLORIDA SPEECH, Language, and Hearing Association (FLASHA) Spring Convention, Jacksonville, Florida. Con tact: Tim Stavropulos, 5720-1 Atlantic Boulevard, Jacksonville, Fl. 32207. (904) 725-4646. ASHA continuing education credits available.

MEDICAL MARKETING — Everything you wanted to know provided in nuts and bolts workshops with time set aside for personal discussion. An annual session sponsored by the Health/Medical Section, Florida Freelance Writers Assn. Friday, May 16, Sheraton Maitland, Orlando. Afternoon, 2-5 for case studies and marketing components. Separate evening workshop, 7-9, for MDs only. Panel includes senior medical marketing consultant; physician author; ghostwriting/editor and publications manager. Coordinated by Health Care Communications of Dade County, (305) 274-0999. For program and registration information call 1-800-851-3392. (Designed for M.D.s interested in establishing their own marketing program and/or evaluating current solo, group and joint ventures).

Miscellaneous

K MED CENTER, INC., seeking possible merger/acquisition candidates. Cash assets inexcess of $1,200,000.00 and no debt. Written inquiries to: 609 S. Main St., Duncanville, Texas 75116.

PUBLIC COMPANY AVAILABLE for sale with no cash outlay. Send written requests to K Capital, 200 W. Colorado Blvd., Dallas, Texas 75208.

BUSINESS OPPORTUNITY: Medically researched and approved weight loss and smoking cessation program available. Regional or national basis. Professionally tested and proven materials, training, testimonials, etc., provided. Ideal for active or absentee investor. Potential net per center is $100,000+. Priced right! Call or write for additional information. Barney Everett, Sherwood-Trans Florida, Inc., Realtor, 1400 S. Orlando Avenue, Winter Park, FL 32789 (305) 628-4400.

Put Our List On Your List

Our list is the free Consumer Information Catalog. It lists more than 200 helpful government booklets. For your free copy, write:

CONSUMER INFORMATION CENTER DEPT. PA, PUEBLO, COLORADO 81009

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

29 Glen Cove Ave., Glen Cove, N.Y. 11542 516-676-4300

Our members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION	(No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
merican Health	(10)	14.95	12.95	11.95	
merican Heritage	(6)	24.00	18.00	18.00	
mer.Photographer	(12)	19.90	9.95	6.65	8
mericana	(6)	11.95	11.95	9.95	
rtNews	(12)	29.95	25.95	25.95	
rtist's Mag	(12)	21.00	21.00	9.97	9
tlantic Monthly	(12)	9.95	9.95	9.95	
udio	(12)	17.94	8.97	8.97	
aseball Digest	(12)	14.95	14.95	7.97	10
asketball Digest	(8)	9.95	9.95	7.97	
Better Hms-Gdns	(12)	12.97	6.49	12.97	
Bicycling	(10)	15.97	8.00	12.97	
lack Enterprise	(12)	15.00	9.00	7.50	
on Appetit	(12)	15.00	15.00	15.00	
oys Life	(12)	13.20	13.20	11.97	
ar & Driver	(12)	17.00	11.99	11.99	
ats	(12)	17.50	17.50	12.50	
at Fancy	(12)	17.97	17.97	12.97	
hanging Times	(12)	15.00	9.97	9.97	
hild Life:age 6-10	(8)	11.95	11.95	9.97	
hildrens Dig:7-11	(8)	11.95	11.95	9.97	
ommentary	(12)	33.00	33.00	33.00	
Connoisseur	(12)	19.95	10.00	19.95	
onsumers Digest		14.97	14.97	10.97	
onsumers Reports	(12)	16.00	16.00	16.00	
COSMOPOLITAN	(12)	**24.97**	**15.00**	**24.97**	
ruising World	(12)	18.00	18.00	14.00	
Discover	(12)	24.00	13.00	14.95	
og Fancy	(12)	17.97	17.97	12.97	
ownbeat	(12)	15.75	15.75	7.95	
bony	(12)	16.00	14.00	9.97	
he Economist	(52)	85.00	51.00	51.00	
llery Queen Myst	(13)	22.75	19.50	9.97	10
squire	(12)	17.94	9.95	9.95	
ssence	(12)	12.00	9.96	9.00	
amily Circle	(17)	14.97	14.97		
amily Computing	(12)	19.97	11.97	11.97	
amily Handyman	(10)	9.95	9.95	5.95	
ield & Stream	(12)	13.94	7.94	7.94	
ifty Plus	(12)	15.00	11.97	11.97	
inancial World	(26)	41.95	24.94	18.95	18
ood and Wine	(12)	18.00	9.00	15.00	
ootball Digest	(12)	12.95	12.95	7.97	10
orbes	(28)	42.00	42.00	28.00	
ortune	(26)	42.00	21.00	21.00	
ames Magazine	(12)	15.97	15.97	15.97	
entlemens Quart.	(12)	18.00	13.50		
lamour	(12)	15.00	12.00		
olf Digest	(12)	19.94	11.97	11.97	
olf Magazine	(12)	15.94	8.97	7.97	
#Good Housekeeping	(12)	14.97	9.97	14.97	
Gourmet	(12)	18.00	13.50	15.00	
#Harpers Bazaar	(12)	16.97	8.97	16.97	
Harpers Magazine	(12)	18.00	9.97	9.97	
Health	(12)	22.00	13.32	11.00	
High Fidelity	(12)	13.95	6.98	6.98	
Home	(12)	15.00	15.00	15.00	
Home Mechanics	(12)	11.94	8.97	8.97	
The Homeowner	(10)	18.00	13.97	9.00	
Hot Rod	(12)	13.94	8.97	8.97	
House and Garden	(12)	24.00	18.00		
#House Beautiful	(12)	15.97	7.99	15.97	
Humpty Oumpty:4-7	(8)	11.95	9.97	9.97	
Jerusalem Post	(24)	18.46	18.46	15.97	
Jet	(52)	36.00	30.00	26.00	
Ladies Home Jrnl	(12)	20.00	15.00	10.00	
#Life	(12)	32.50	16.25	25.00	10
M:Civilized Man	(12)	24.00	19.95	17.95	10
Mademoiselle	(12)	15.00	12.00		
#McCalls	(12)	11.95	11.95	11.95	
Metropolitan Home	(12)	15.00	7.50	7.50	
Modern Photography	(12)	13.98	7.98	6.99	
#Money	(12)	29.95	15.00	19.95	
Mother Jones	(12)	18.00	12.00	12.00	
Motor Trend	(12)	13.94	7.97	7.97	
MS Magazine	(12)	16.00	10.97	10.97	
The Nation	(52)	28.00	28.00	9.95	24
Nation's Business	(12)	22.00	12.97	12.97	
Natural History	(12)	20.00	15.95	15.95	
N.E.Journal of Medicine	(52)	60.00			
New Republic	(52)	48.00	48.00	28.00	
#New Shelter	(9)	10.97	5.50	9.97	
N.Y. Rev.of Books	(17)	28.00	28.00	25.95	
New Yorker	(52)	32.00	32.00	20.00	
#Newsweek	(52)	41.00	21.80	21.80	
Omni	(12)	24.00	15.96	15.96	
1001 Home Ideas	(12)	22.00	15.97	11.00	
Organic Gardening	(12)	12.97	9.97	9.97	
Outdoor Life	(12)	13.94	7.97	7.97	
Outside	(10)	16.00	12.00	8.97	
Ovation	(12)	16.00	8.00	8.00	
PARENTS	(12)	18.00	9.00	11.95	
Penthouse	(12)	36.00	30.00	30.00	
People	(52)	56.50	56.50	28.25	
Personal Computing	(12)	18.00	18.00	8.97	9
Petersens Photog	(12)	13.94	6.97	6.97	
Playboy	(12)	25.00	21.50	21.50	
#Popular Mechanics	(12)	13.97	7.00	13.97	
Popular Photogr.	(12)	11.97	5.99	5.99	
Popular Science	(12)	13.94	7.97	7.97	
#Prevention	(12)	13.97	7.00	13.97	
Psychology Today	(12)	15.99	8.00	12.97	
Reader's Digest	(12)	15.41	15.41	15.41	
#Redbook	(12)	11.97	6.97	11.97	
Road and Track	(12)	17.94	11.99	12.99	
Rolling Stone	(26)	19.95	19.95	17.95	
The Runner	(12)	16.97	12.97	8.97	
#Runner's World	(12)	19.95	10.00	12.97	
Sail	(12)	21.75	21.75	21.75	
Saturday Eve.Post	(9)	12.97	12.97	12.97	
Savvy	(12)	12.00	12.00	6.00	
Science '86	(11)	18.00	18.00	13.95	
#Science Digest	(12)	13.97	6.99	13.97	
Scientific Amer.	(12)	24.00	24.00	24.00	
Self	(12)	15.00	12.00	N.A.	
Seventeen	(12)	13.95	13.95	13.95	
Shape	(12)	20.00	20.00	8.97	6
Ski	(8)	11.94	6.97	6.97	
Skiing	(7)	9.98	4.99	4.99	7
Skin Diver	(12)	13.94	7.97	7.97	
Sport	(12)	12.00	7.97	7.97	
Sporting News	(24:6 mo)	22.50	11.97	11.97	
#Sports Afield	(12)	13.97	6.99	13.97	
#Sports Illustr.	(54)	56.50	34.00	29.45	
Stereo Review	(12)	9.97	4.99	4.99	
Teen	(12)	12.95	7.95	7.95	
Tennis	(12)	17.94	8.97	8.97	
#Time	(52)	58.25	29.25	28.00	50
#Town & Country	(12)	24.00	12.00	24.00	
Travel & Leisure	(12)	25.00	12.50	25.00	
TV Guide	(52)	31.20	31.20	26.00	
#U.S.News/Wrld.Rep	(52)	41.00	20.50	20.50	
Vegetarian Times	(12)	19.95	14.95	14.95	
Video	(13)	15.00	15.00	7.50	
Video Review	(12)	12.00	6.97	6.97	
Village Voice	(52)	32.76	32.76	22.00	
Vogue	(12)	24.00	21.00		
W Magazine	(26)	26.00	23.00	17.95	
Weight Watchers	(12)	13.97	11.97	11.97	
Woman's Day	(17)	15.13	15.13	15.13	
Women's Sports	(12)	12.95	12.95	8.95	
Workbench	(6)	6.00	6.00	5.00	
Working Mother	(12)	11.95	9.95	9.95	
Working Woman	(12)	18.00	12.00	15.00	
World Press Review	(12)	16.95	16.95	14.98	
Writer's Dig.	(9 iss)	18.00	9.97	9.97	
Yankee (Colonial)	(12)	15.00	15.00	12.97	
YM	(12)	14.00	10.95	10.95	

#BUSINESS CARD NEEDED FOR OFFICE PRICE

HUNDREDS OF OTHER TITLES AVAILABLE! PLEASE SEND US YOUR REQUESTS!

FMA MAGAZINE PROGRAM
29 Glen Cove Ave., Glen Cove, N.Y. 11542

MAIL MAGAZINES TO:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AFFILIATED HOSPITAL/SCHOOL _____
Required for Educator rates

VISA or M/C No. _____ Exp. Date _____

Prices subject to publishers' changes.

PLEASE SEND THE FOLLOWING MAGAZINES:

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

All subscriptions are for one year unless otherwise noted.
Guarantee: Our prices are the lowest, our service the best.
New Orders: Publishers take from 6 to 12 weeks to start your subscription.
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.

Please make checks payable to: FMA Magazine Program

FLMD186

ADVERTISERS

Air Force Reserves
Recruitment . . . 335

American Medical International
Recruitment . . . 253

Ayerst Laboratories
Inderide LA . . . 266c

Brown Pharmaceutical
Android . . . 256
Lipo-Nicin . . . 271

Curtis 1000 Information Systems
Computers . . . 250d

Eli Lilly & Company
Ceclor . . . 272

Florida Physicians' Insurance
Service . . . 250

GTE Telenet
Service . . . 252

Health Care Personnel Consulting
Recruitment . . . 346

Info Systems
Computers . . . 335

Knoll Pharmaceutical Company
Isoptin . . . 346b
Vecodin . . . 250c

Lucerne Spinal Injury Center
Health Care Witness Conference . . . 265

Marion Laboratories, Inc.
Cardizem . . . 266a

Medical World News
Publication . . . 328

The Physician and Sportsmedicine
Publication . . . 256

Polk County Medical Association
Meeting . . . 264

Roche Products, Inc.
Dalmane . . . 355

Searle Pharmaceuticals, Inc.
Service . . . 251

Shari Medical Center
Recruitment . . . 263

Smith Kline & French Laboratories
Dyazide . . . 250b, 346a

The Tampa General Hospital
Service . . . 344

University of Alabama
Service . . . 326

University of Miami
Meeting . . . 271, 336

Upjohn Company
Motrin . . . 250a

Willingway Hospital
Service . . . 328

Wyeth Laboratories
Ativan . . . 265

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

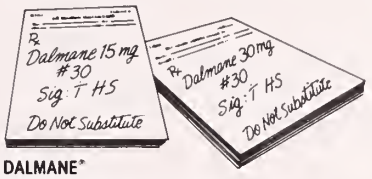
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
brand of
flurazepam HCl/Roche Ⓒ
sleep that satisfies

15-mg/30-mg
capsules



References: 1. Koles J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Koles A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Koles A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Koles A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Koles A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al*: Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblott DJ, Allen MD, Shoder RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
brand of
flurazepam HCl/Roche Ⓒ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see preceding page for summary of product information

DALMANE®
brand of
flurazepam HCl/Roche Ⓡ
sleep that satisfies



C01183 000 28
COLL.OF PHYS.OF PHILADELPHIA
LIBRARY
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

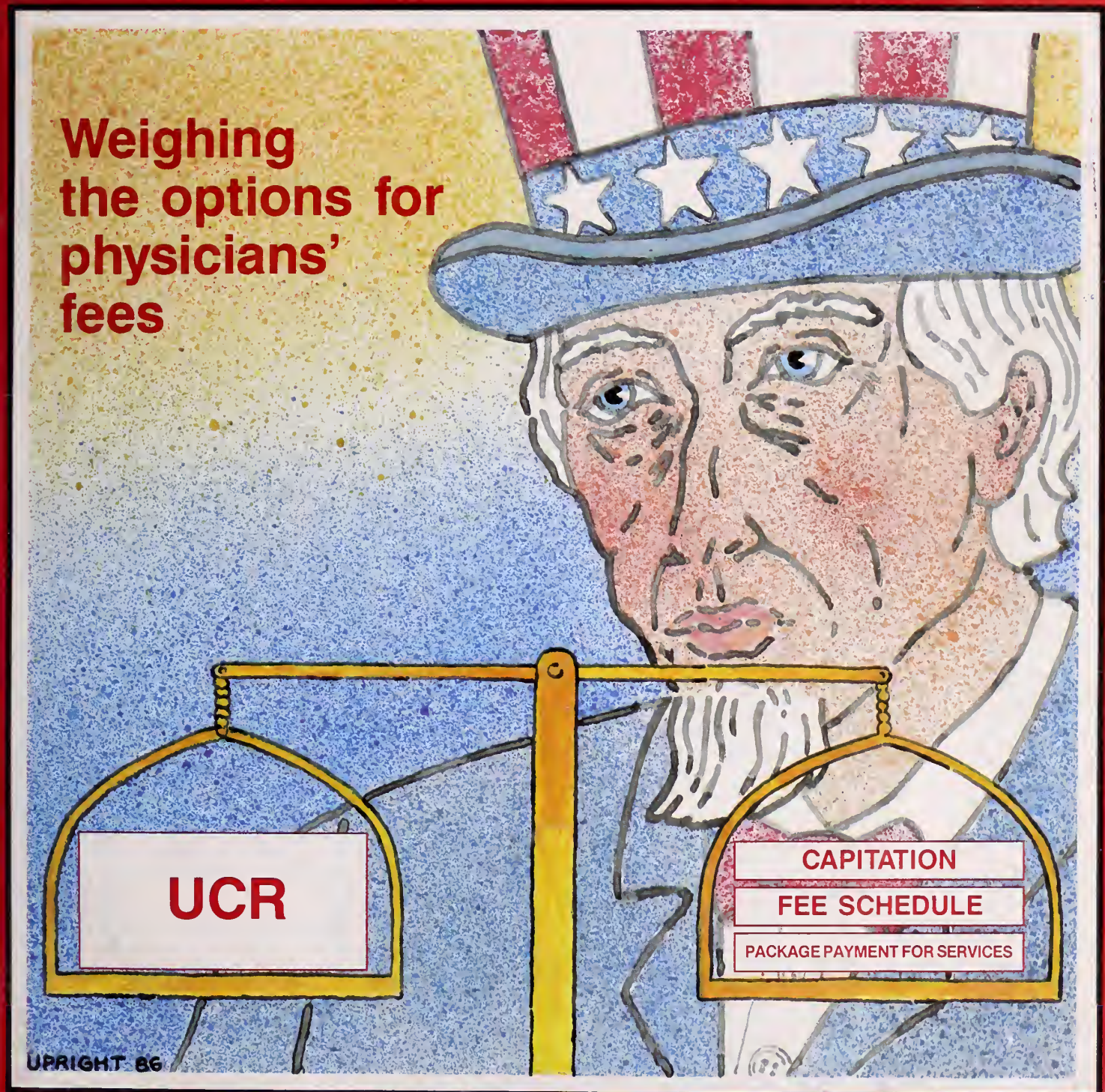
ROCHE®

Copyright © 1986 by Roche Products Inc All rights reserved

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. MAY 1986, Vol. 73, No. 5

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JUN 4 - 1986

Weighing the options for physicians' fees





FPIC

for the long run.

Florida Physicians Insurance Company (FPIC) prides itself in its professional management team backed by a Board of Directors with a majority membership of physicians representing the insureds.

FPIC provides stability and direction for the long run and is non-assessable. Be prepared for the long distance trek ahead by insuring with the "anchor" professionals . . . Florida Physicians Insurance Company.

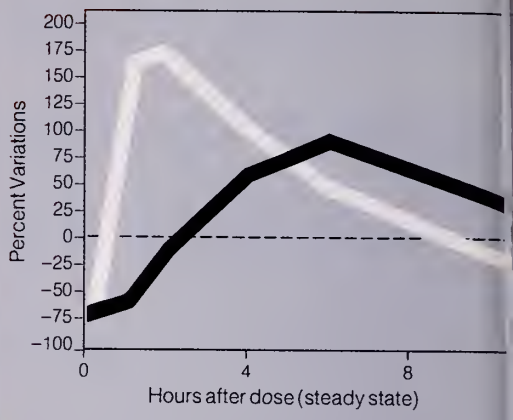
FPIC FLORIDA PHYSICIANS INSURANCE COMPANY

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349


Easy to live with



INDERAL LA and



- INDERAL LA avoids the sharp peaks seen with atenolol

Blood pressure controlled,

Smooth blood pressure control and well tolerated

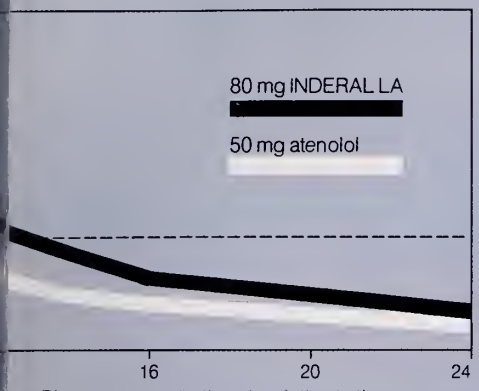
Once-daily INDERAL LA (propranolol HCl) keeps life simple for the patient. A single dose provides 24-hour blood pressure control. Convenient and well tolerated, INDERAL LA rarely interferes with everyday living. In fact, a recent study of 138 patients found a low incidence of side effects with INDERAL LA, which was not significantly different from that reported with metoprolol and atenolol.[2]

INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

Once-daily
INDERAL® LA
(PROPRANOLOL HCl) *Long Acting Capsules*

Please turn page for brief summary of prescribing information.

atenolol over 24 hours*[1]



*Plasma concentrations in relation to the mean.

- Smooth, consistent plasma drug levels over 24 hours
- Full, 24-hour blood pressure control with INDERAL LA



and feeling good.

Added blood pressure control with the preferred diuretic

When more than one antihypertensive agent is needed, once-daily INDERIDE LA enhances patient compliance to improve long-term control. Patients receive all the benefits of controlled-release INDERAL LA *and* standard-release hydrochlorothiazide (HCTZ), for comfortable morning diuresis. Not only does this regimen permit patients to follow normal daily routines, but HCTZ also produces less potassium wastage on a mg-for-mg basis than chlorthalidone.[3,4]

Once-daily
INDERIDE LA
(PROPRANOLOL HCl [INDERAL® LA]
/HYDROCHLOROTHIAZIDE)

As with all fixed-combination antihypertensives, INDERIDE LA is not indicated for the initial treatment of hypertension.

Please turn page for brief summary of prescribing information.

Once-daily INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories

Once-daily INDERIDE® LA

Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS)*

INDERAL® LA Brand of PROPRANOLOL HYDROCHLORIDE **(Long Acting Capsules)**
INDERIDE® LA Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE **(Long Acting Capsules)**

INDERAL LA AND INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis; ischemic colitis.

Allergic: Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia; LE-like reactions; psoriasiform rashes; dry eyes, male impotence; and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia; gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias; headache; xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash; urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis); fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia; glycosuria; hyperuricemia; muscle spasm, weakness; restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

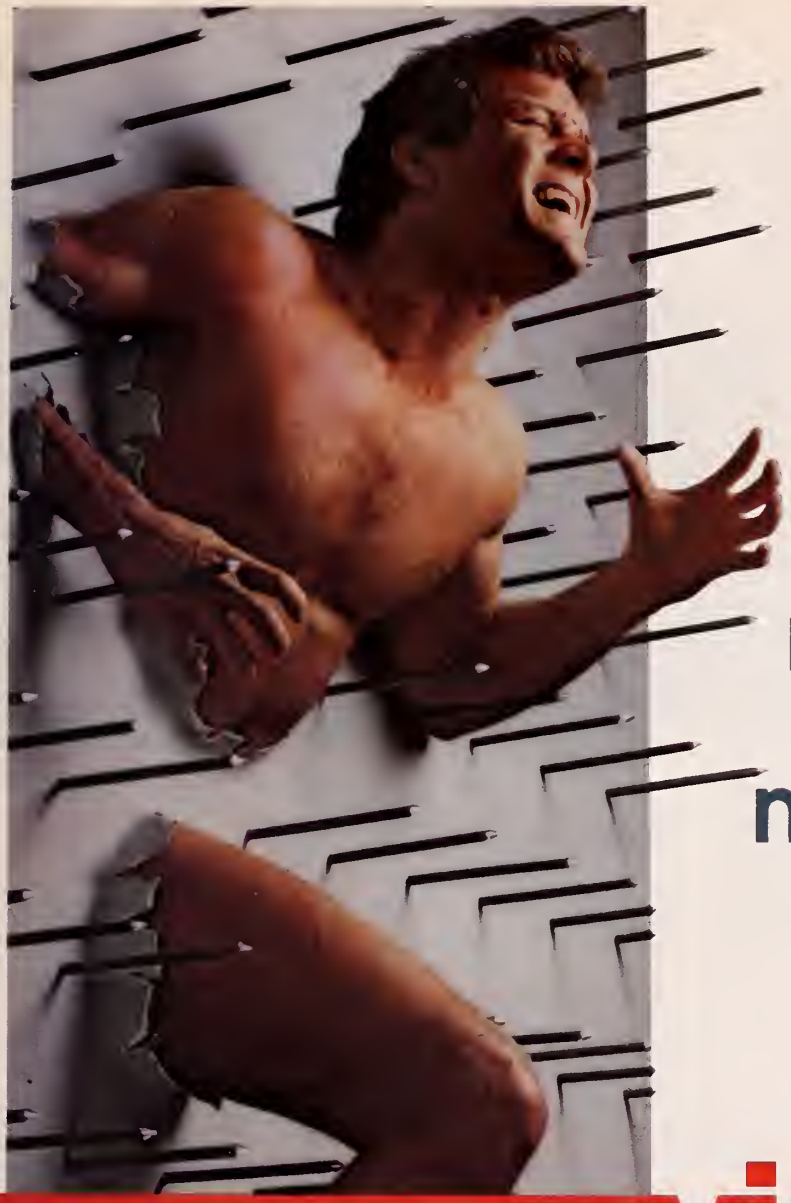
REFERENCES

1. Data on file, Ayerst Laboratories. **2.** Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321-1323. **3.** Sumiye L, Vivian AS, Frisof KB, et al: Potassium loss associated with hydrochlorothiazide versus chlorthalidone. *Clin Ther* 1981;4:308-320. **4.** Ram CVS, Garrett BN, Kaplan NM. Moderate sodium restriction and various diuretics in the treatment of hypertension. *Arch Intern Med* 1981;141:1015-1019.

5593/486

Ayerst AYERST LABORATORIES New York, NY 10017

© 1986 Ayerst Laboratories



To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
with acetaminophen 500 mg

Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.
Revised, April 1982.

5725

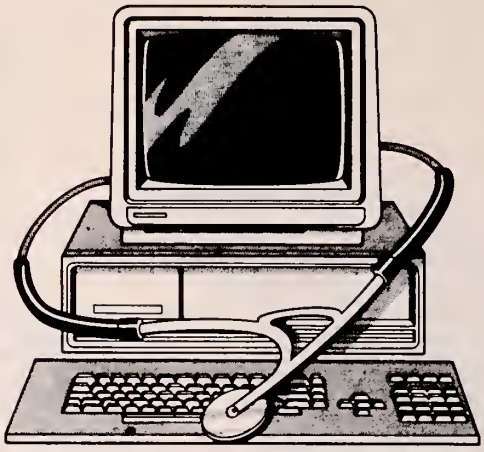
knoll® KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

February, 1985

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

DON'T GET OUT OF PRACTICE.



Join Shari Medical PRACTICE MADE PERFECT.

All through medical school you wanted your own practice. Now you have it, but you can't help but notice your phone doesn't ring as often as you'd hoped. With the introduction of HMO's and PPO's it's becoming increasingly difficult to maintain a successful private practice. However, you've worked hard, and you don't want to give up your independence.

Keep your independence but receive the benefits of a group practice

At Shari Medical Center, we believe in physicians helping physicians to increase business. Therefore, every Shari Medical Center is staffed with at least fifteen Primary Care doctors to care for the volume of patients needing general treatment. They will refer exclusively to the Shari specialists-only one physician for each of fifteen specialties.

Plans are for twenty Shari Medical Centers throughout Florida. The locations for each one of these centers has been researched carefully to determine the area with the greatest patient need, and each center will have carefully chosen physicians to fill that need.

Once each physician is invited to join, we'll do everything possible to make sure the practice succeeds. For you as a Shari physician that means state-of-the-art equipment as well as the finest administrative, management, and marketing services that a physician in a small practice couldn't possibly afford.

Most importantly, as a Shari physician, you maintain your independence, so your practice is still your own. You'll receive an equity position in the center and compensation for the services you provide, but you'll have the advantage of exclusive referrals from 30 physicians who are determined to see your practice succeed. Because, when you succeed, everyone succeeds.

Call Shari Medical at (305) 726-6000, outside Broward County, Florida call 1-800-SHARI MD (742-7463)

To find out more about Shari Medical Center, call us. Or, write to us at the address below. We'll be glad to send you a brochure and give you more information on how it is possible to start and maintain a successful practice—made perfect by Shari Medical Center.

SHARI MEDICAL CENTER

Shari Medical Centers, Corporate Offices, 7310 West McNab Road, Suite 103, Tamarac, Florida 33319

©1986 – Shari Medical Center

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

MAY 1986, Vol. 73, No. 5

CONTENTS

SCIENTIFIC ARTICLES

John H. Isaacs Jr., M.D., George T. Singleton, M.D., and Michael Mokris, M.D. **377** Meniere's Disease

Muhammad Saeed, M.D., F.A.G.S., and Charles E. Barrineau, M.D., F.A.C.S **381** Posttransfusion purpura — a rare manifestation of blood transfusion

Stephen Sandroni, M.D. **384** Severe post-TURP syndrome in patient with renal insufficiency: treatment with hemofiltration.

SPECIAL ARTICLES

Richard J. Feinstein, M.D. **387** Physician payment plans and conflicts of interest

Waite S. Kirkconnell, M.D., F.A.C.S., Tully C. Patrowicz, O.D., M.S., M.D., and Ronald W. Case, M.D., F.A.C.S. **390** Medical eye care by optometrists: retospective review 1977-1983

COVER

This month's cover of *The Journal* is a drawing by James B. Upright, a Jacksonville artist. It relates to several articles featured in this issue concerning options for physician's fees.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.* [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc., are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Florida Medical Association, Inc.

DEPARTMENTS

363 President's Page

Luis M. Perez, M.D.

365 Editorials
Physicians' fees: what's ahead?
R.G. Lacsamana, M.D.
The bottom line
James K. Conn, M.D.
Responsible reporting or yellow journalism?
H. Frank Farmer Jr., M.D., Ph.D.

371 Letters and Viewpoints

401 Medical Economics
Proposals for capitation reimbursement of physician fees
Jacques R. Caldwell, M.D.

407 Notes & News

408 Dean's Message

409 Encores!

415 Book Review

417 FMA Auxiliary
We care. . .in many ways
Mrs. Marcos (Susan) Lima

420 Meetings

424 Classified Advertising

430 Index to Advertisers

430 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Karl Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.

For Your Benefit...

From The Florida Medical Association Sponsored Insurance Plans.

Diagnosis: FMA Members and Employees, Need Dependable, Comprehensive Coverage In Medical Care, Life, Disability and Dental At Economical Group Rates

Treatment: Enroll NOW in Your Florida Medical Association Sponsored Insurance Plans

Prognosis: Excellent. FMA-SIP Offers Flexibility, Convenience, Efficiency In An Insurance Package Designed Exclusively For You.

•Major Medical •Dental •Short-Term Disability •Life And AD&D

☐ Developed from your specifications by your Association and offered exclusively to FMA members and their employees. Dependents coverage available for Medical and Dental benefits.

☐ Marketing by Florida's leading insurance consultant, Brown and Brown, Inc., for further information contact us at the toll free number below.

☐ Underwritten by one of America's largest and strongest insurance companies, Mutual of Omaha.

☐ Administered by FLAMEDCO, Inc., highly regarded for rapid, efficient claims and enrollment administration and a wholly owned subsidiary of your own Florida Medical Association.

FMA/SIP Offers You Great Flexibility. You Choose The Coverage You Need:

Major Medical, Million-dollar protection with your choice of $200 or $500 annual deductibles and the new Medical Deluxe Plan.

Dental, Benefits of up to $1,000 per person each year. Optional if you elect Major Medical.

Life, Group term life insurance coverage for you and your employees. You select coverage level from $10,000 to $100,000.

Disability, If you elect life insurance, you also may choose from among four short-term disability options, either 13-week or 26-week coverage with or without maternity.

Call Toll-Free
1-800-624-3953 *For Details*

760 Riverside Avenue
Jacksonville, Florida



Florida Medical Association, Inc.
Sponsored Insurance Programs

PRESIDENT'S PAGE

The fight is not over



Since April 21st, the highly successful Day in the Right Direction, our work in Tallahassee has been continuous with your President-Elect and I there every week. Several delegations of physicians from all over the state have been visiting their legislators and testifying at committee and subcommittee meetings and expressing in a very forceful manner the views of your Association on the numerous issues that affect our profession.

The members of the Florida Coalition for Liability Reform have also been extremely active, working in a very effective way for the cap of $250,000 for non-economic damages. As this issue of *The Journal* goes to press, the fight will not be over. It looks as if the final resolution of the principal issues is going to be delayed unitl the very end of the session. This common tactic used by the attorneys within the legislature allows for use of all possible time in order to convince other members to their side of the issue. We are going to be there, watching the legislators eye to eye and counting votes and alliances on the floor for evaluation and consideration of our position in upcoming November elections.

The physicians of the state have to realize that this problem cannot be solved if we persist in keeping ourselves out of the political arena. It is not demeaning or unprofessional to exercise our rights as citizens by participating in political campaigns, helping our friends in the legislature and attacking our enemies that so far have enjoyed a free ride without serious opposition on our part. I do not mean that doctors should run for office all over the State — the ones so inclined are welcomed and we will help them — but we can all actively participate in the process.

We should organize in every district a political committee along with the members of the Coalition within these districts. Together we can raise monies for the candidates of our choices and what may be more important is to volunteer some of our personnel to stuff envelopes, man telephone banks, or organize coffees and gatherings to provide an increase in the exposure for the candidates and enhance the possibilities of winning or either maintain the position in the legislature or defeat our enemies. We have to continue showing our strength to the legislators and make them respect that strength if we are going to prevail in Tallahassee.

The Day in the Right Direction produced a reaction that never has been seen in the Capitol. The Speaker of the House and the President of the Senate informed us in November that the liability problem was solved and they were not going to take it up again this year with the members of the Legislature. As a result of our efforts and those of the Coalition, it is the most pressing issue in the Legislature this year, because the members themselves have made it an issue as a response to our demonstration of strength and the justice of our cause.

We have to keep the pressure on the legislators. From now until the end of the session we must continuously ask our friends, our patients, the people that work with us, pray with us, or socialize with us to call, write or send telegrams to the legislators. We must all ask the legislators to vote for a clean $250,000 cap, abolition of mandatory insurance and at least a modification of joint and several liabilities. In order

to be effective, we must do it now, today, before the session is over.

Once the session is over we are going to analyze the attitudes and votes of each one of the members of the House and Senate. From this analysis we will draw our conclusion on which areas we have to be especially active in the upcoming November election, in order to properly reward our friends and eliminate our enemies.

We cannot lose the momentum, we have to take the initiative and demonstrate that we have reached the limits of our patience and conformity. We are now ready to fight in the same grounds and with the same rules that the enemy has been using so effectively.

I will be talking to your societies and your executives right after the session is over and the evaluations of the candidates are ready. Do not let your enthusiasm diminish, do not let your spirit of combat decrease. Let us all continue our fight by saying, like the Jacksonville Obstetrical and Gynecological Society: "Enough is Enough!"



Physicians' fees: what's ahead?

Close on the heels of its DRG scheme for hospitals, the HCFA is now focusing on physicians' fees as the next big target for its cutting axe. Although it is well known that these fees constitute only 19% of annual Medicare reimbursements, HCFA is contending that they are the fastest growing segment of the federal budget, rising at 16% annually and outpacing inflation for the past few years. Physicians' fees of course have been frozen since October 1984 and will remain frozen till the end of this year. But most physicians know that the freeze is nothing more than a stop-gap measure aimed eventually at dismantling the entire fee structure system. Now that the Federal Office of Technology Assessment (OTA) has finally come up with its report on Medicare reimbursement strategies, HCFA officials are feverishly looking at what option to adopt when the fee freeze is over.

Physicians' fees, as opposed to hospital reimbursements, have traditionally escaped the attention of budget officials because they have been for the most part reasonable and, as noted earlier, made up only a small fraction of the total Medicare outlay. Furthermore, most patients until a few years ago were insulated from the impact of these fees since their insurance coverage took care of a large percentage of their bills. But that situation has drastically changed. Now both the government and private insurance companies are not only increasing co-payments from patients, but are demanding as well more accountability from physicians and other health providers for their services. Over the past few years, the government has been casting baleful eyes over some quirks of the reimbursement system such as the wide geographical variations in fees for the same services, the increased intensity of medical services and procedures in some areas and the exorbitant fees charged for certain services and procedures. Within the medical profession itself, a subdued type of internecine warfare has been brewing for sometime among physicians because of disparities in payments for cognitive services as opposed to procedures. All these have made it easier for the government to step in and set the stage for current efforts to recast the entire system for paying physicians.

Beyond all the perturbations concerning the future of physicians' fees, there has been widespread criticism of the current UCR (usual, customary, and reasonable) system which has been in existence for the past several years. Critics charge that the system is cost-based and therefore expensive, allows wide disparities in fees for the same services, encourages certain physicians to perform a number of expensive procedures, and does not take into account a physician's training and experience, the time to render a service, and the relative difficulty in doing procedures. Moreover, physicians who for years have tried to place reasonable curbs on fee increases are disturbed to find out that those just starting out in practice can get immediate hefty fees and better reimbursement profiles. Certain procedures also become more expensive instead of getting cheaper as more physicians are able to do them. Against the frenzied efforts of the government to cut costs, there is little hope that the UCR system will be here to stay.

With the OTA report now out, speculation is rife on what system the government is going to pursue to pay physicians in the future. Once the government makes its choice, it is logical to expect that private insurers will make the same move. What are the choices? OTA outlines four options: retain the present UCR system, go on a fee schedule system, pay for a package of services, or adopt capitation. Most physicians would favor a fee schedule based on relative values, but the government appeared to have aban-

doned the idea on the premise that it is also cost-based and probably not much cheaper than the UCR system. Package payment of services is relatively new and probably will not be considered seriously. The sentiment is strong that HCFA will go for the capitation system, which most physicians oppose. A capitation system has the potential to make big groups such as HMOs and fiscal intermediaries such as Blue Cross too powerful, will strip away the independence of physicians, and perhaps encourage abuses by making physicians skimp on services. The AMA is taking a cautious approach to the idea as the HCFA is now getting ready to start demonstration projects on the system.

Whatever form and shape fees are going to take, physicians can be certain that the advent of a new reimbursement system will presage another chapter in the continuing saga by the government to restructure the country's health system. Most of us can only hope that in doing so, the government is not inexorably leading us down the path of socialized medicine. It is a terrible thought, but it can happen.

R. G. Lacsamana, M.D.
Editor

The bottom line

I am sure that most doctors able to think objectively accept the notion that we have been guilty of the profligate use of medical resources in recent years. It is not bad medical practice and we have actually been encouraged to do it — until now. When a hospital room costs little more than a good hotel room, why not use it as such? Today, however, the hospital cost involves much more than room, board, and personal care. It is technology-intensive and it is expensive. We are requircd to change our styles, to not hospitalize our patients unless they absolutely must have the technology available only there. There have been rumblings of this nature for years and we have agreed in principle that, yes, this was desirable. We have pledged in the past that we would make an honest effort to reduce utilization and thus lower costs. However, our efforts have not been perceived as good enough and I guess that could have been forecast since the utilization incentives were not changed. Now, though, the incentives have been changed and it is a new ball game.

The Prospective Pricing System has now made it financially attractive to undertreat and to hospitalize only the easy cases, patients who, perhaps, could be treated in a different setting. Thus we have perverse influences that could threaten the quality of care we provide and still encourage inappropriate utilization of expensive resources. These are the perversities of the system and thus it will always be in a managed economy. Of course this was recognized from the outset and the establishment of an agency, the PRO, was authorized to combat these influences.

Time passes swiftly and it has now been two years since HCFA contracted with PROs to provide utilization and quality reviews for Medicare hospitalized patients. The initial contracts were for two years and it is now time for renewals. In several states the contract has not been renewed. There are a number of reported reasons for the non-renewals, such as inadequate performance, unsatisfactory results, and excessive costs. From news items that have appeared it has been evident that extreme pressures have been exerted on the PROs, by HCFA, to reduce hospitalization rates to ever and ever lower levels. In those areas with very acceptable rates, the PROs have been taken to task for not reducing them even more. At some point, there must be a bottom line, a point beyond which no further reductions can be made without abandoning our mission to alleviate pain and suffering by treating the sick and injured to the best of our abilities, and to the extent of our capabilities. It would be nice if we could eliminate the need for hospitals by preventing all serious illness and by keeping all citizens free from harm, but until that day comes we will need them and will need them to be good.

Medicare has contracted with certain of society's elderly members to pay for their necessary medical care needs. It is finding it much more expensive than planned. HCFA is charged with making the available money stretch far enough to pay for the needed services. The PRO, in turn, is mandated to assure that no unnecessary or inappropriate hospital services are provided and yet to make certain that the quality of care is not compromised thereby. It would seem that this is a reasonable goal to which we can all subscribe. It is also self-evident that it takes a physician's expertise to determine medical necessity and evaluate the quality of care. I resent it then when HCFA forces the patients, the doctors, and PRO into adversarial positions by an uncompromising assault on that bottom line.

Currently the PRO is a physician-controlled organization, but it needs all the help and cooperation it can get from the practicing doctors. Utilization controls must be clinically acceptable. Imposition of controls that make us behave in clinically unsound ways is not desired by the PRO and pressure to impose them in efforts to improve performance statistics must be resisted. The PRO can be our ally when we serve as the patient's advocate. Together we can achieve an irreducible level of utilization and maintain an optimal level of quality. That is the bottom line and when it is reached we can challenge, and society can demand, that Medicare find the funds.

James K. Conn, M.D.
Tallahassee

Responsible reporting or yellow journalism?

Recently, a series of articles on doctors and malpractice appeared in the *Orlando Sentinel* which, to say the least, made physicians look largely incompetent, devoid of moral courage for not policing our ranks more effectively, and responsible for the malpractice crisis. It is obvious that the co-authors of the series did a tremendous amount of work and researched hundreds of cases. This is not to imply that I am an admirer of the series. Rather, it is a recognition that the work was not written off the top of their heads. The series is an example that what is presented as fact can be influenced by the point of view of the author. As I read the articles I knew that I was a biased reader. I am a physician. I think the tort system is going to have to be changed in order for the liability question to be resolved or put on the road to a solution.

I feel that the articles led many readers to the wrong conclusions. What is stated in a legal document from a plaintiff's attorney may not be the true case at all. Since many of the cited cases were taken from court records, the point of view and the language of malpractice, negligence, wrongful deeds, etc., are that of the plaintiffs' attorneys. I understand this. Other doctors understand this. Attorneys understand this. The problem is that the vast majority of the public do not understand this. They accept the language of legal accusation as the language of fact and truth. So be it. I suppose that I accept this as a reality of life no matter how unfair this seems. However, I do question whether the reporters who spent so much time on the preparation of the articles know the difference. It strikes me as improbable that the reporters would not come to this knowledge as they poured over the court records, spoke to attorneys, physicians and people proclaiming themselves as victims of malpractice. If, indeed, the reporters did come to the realization, I did not gather it by the reading of the articles. If this is the case, then the reporters have not revealed all the facts about the malpractice crisis. If there is more to be added, whether it be nuances of language or point of view which influences the approach to the writing of the articles and that is left out of the presentation, then that presentation has been flawed.

I am not by training a journalist. I am a historian and that involves communication by the written word. I am not versed in the ethics of journalism, although I know that journalism is dissemination of news to the public. That task carries with it the commitment that it is going to be based on as much information as that journalist can gather. There seems to be a view that journalism does not distort facts or attempt to present the facts in such a way that will incite or inflame the public unless the facts themselves create that impression. If this is valid, then presenting some facts that lead to certain conclusions which may be different if additional facts are presented is distorting the news, a concept to which most journalists, I assume, do not subscribe.

I write from a physician's point of view and perhaps I expect too much from members of other professions when examining the medical profession. If this is the case, then I suppose that the writers of these articles may not have come to the conclusion that many of the words used to describe the actions of a doctor when taken from court records are an accusation and that what is truth and what is accusation are often hard to separate. It is especially hard to separate if a physician's insurance company decides to settle out of court. All physicians know that a case settled out of court is not an admission of guilt to any of the accusations. It is because the insurance companies have decided this is the most expeditious and least expensive way for them. It is not always in the best interest of the physician. As all physicians know, the doctor has little say in the matter in many cases.

As one reads the series, it is difficult to see that this distinction is made. Perhaps it is and I simply missed it either by reading a very voluminous amount of material or subconsciously subduing it because of my own personal prejudices. If it was not present, then this is a very distorted view of the malpractice crisis. By implication this limits the accuracy of the series. If it is not accurate, then the writers have not fulfilled their responsibilities to the readers. Speaking from a historian's point of view, this abrogation of responsibility has been unfavorably reviewed when analyzing events of the past. Specifically, I am reminded of the term "yellow journalism" which appeared in the late 1890's in response to Cuban rebels' efforts against the Spanish rulers of Cuba. For most of that decade Americans followed events with deep interest and emotions. Most American citizens were sympathetic to the rebels from 1890 to the outbreak of the war in 1898. Two newspapermen, Joseph Pulitzer of the New York *World* and William Randolph Hearst of the New York *Journal*, revolutionized American journalism with reporting that specialized in lurid and sensational news. Where news did not exist, editors were not above creating it. Both papers sent reporters and illustrators to Cuba with news to provide plenty of details and pictures of the account of Spanish atrocities — often times without being too careful to check their accuracy. The country was inundated with details of torture and other horrible acts by the Spanish rulers. The citizens of the United States eagerly bought the newspapers and formed the public opinion that would lead President McKinley to declare War on Spain in 1898, a war that was described and perhaps best summed up the feelings of Americans as a "splendid little war." Americans did not seem to mind that sometimes distorted facts had created a fertile, receptive audience for the sale of newspapers.

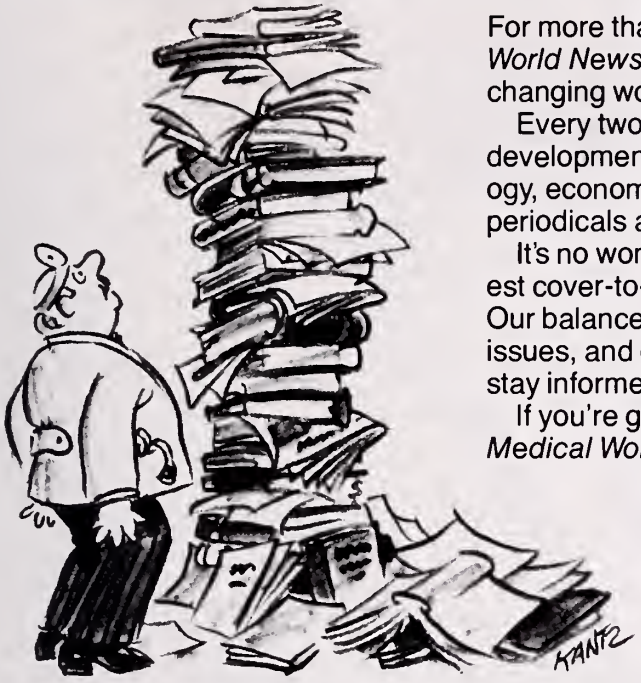
In some ways the society in which we live is a fertile, receptive audience for any "expose" of doctors. As we all know, the way in which physicians are viewed by American society has changed drastically over the past 40 years. This is a study in itself and there are many espoused reasons for our decline in public respect, but suffice for this article to state at the present time we are held in low esteem by much of the public. Anything that strikes out at physicians gets an immediate and ready acceptance by much of the population. If the facts are left out or presented in a slanted way, then the public has been misled. Whether this is by misinformation, misinterpretation or personal bias of the author, the result is the same.

I am at a disadvantage when reviewing the cases that the *Orlando Sentinel* gave as evidence for physicians' misbehavior. As stated at the beginning of this article, the writers obviously spent much time on the series. As they said, it represents nine months, took them from New York to California and includes reviewing every malpractice suit filed in Orange County during the fiscal period 1980-1984. To conclude that the reporting was inaccurate in many cases or just a few individual cases would require a review of all these cases. I have not done that. However, a review of the cases presented in the *Sentinel* shows that, at least in some of them, a conclusion was reached that is not in step with reality. One example involved an orthopedic surgeon who had four malpractice law suits filed against him. He was dropped from one suit and the other three suits were settled out of court. One of the cases involved a teenager whose renal rickets went undiagnosed, leading to kidney failure. The orthopedic surgeon recognized that there was a problem and sent the patient to a hematologist and a pediatrician for further tests, but apparently the diagnosis was not made. The hematologist and pediatrician did not have a suit filed against them as the statute of limitations had expired. The orthopedic surgeon was the only one left. His insurance company felt jurors would be swayed by emotions and settled for $400,000. One may argue the medical profession was to blame as the hematologist and pediatrician should have made the diagnosis, but where is it written that an innocent member of the profession or the profession itself should bear the stigma? Furthermore, there may not have been a stigma. Perhaps the hematologist and pediatrician did not deviate from the standards of medical care. There are many cases in which all the proper tests are made, all the steps are followed and a diagnosis of a disease is not made and that disease may surface at a later time. The pediatrician and the hematologist's side will not be presented, just as the orthopedic's side was not presented as his insurance company felt the risk of going to trial was too high. This does not mean that the insurance company felt that the orthopedic surgeon had deviated from an acceptable standard of care. They felt that a jury may be emotionally swayed and give the patient a large award. To the average layman, it may seem that if an insurance company was willing to settle out of court, there must be some guilt involved. Wrong. Settlements are based on other factors besides guilt or innocence. Not every bad result is synonymous with malpractice.

There is no doubt that the medical profession has helped to create an atmosphere in which the public has come to dislike and mistrust doctors. Past sins on our part should not condemn us to purgatory forever. We need to clean our house. We are trying to do this. We have a long way to go. However, this does not excuse a prejudicial view that may be created by incomplete or distorted information. Only the writers of this series know if they were aware of the nuances and subtleties that distinguish accusations from facts, the role the insurance companies and emotions of juries play in settling out of court. The indisputable fact is that right or wrong, malpractice or simply bad results, guilt or innocence is often determined by factors other than the truth, often to the detriment of a physician's reputation and the medical profession's esteem.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor
New Smyrna Beach

Getting behind in your medical reading? Let *Medical World News* put you ahead.



For more than 115,000 busy physicians like you, *Medical World News* is the secret to staying informed about the changing world of medicine.

Every two weeks, we will bring you up-to-the-minute developments in therapy, research, practice, pharmacology, economics, legislative action, highlights of other periodicals and new medical trends.

It's no wonder *Medical World News* has one of the highest cover-to-cover readerships in medical publishing today. Our balanced reporting means you'll get all sides of the issues, and our fast-reading style makes it enjoyable to stay informed.

If you're getting behind in your medical reading, let *Medical World News* put you ahead.

medical world news The credible source.

©1986 HEI Publishing. All rights reserved.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5mg Buccal/10mg Oral/25mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10mg





MEDICAL STAFF DECISION-MAKING

Hospital Medical Staff Section
Seventh Assembly Meeting

JUNE 12-16, 1986

HYATT REGENCY HOTEL
CHICAGO

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
Phone (312) 645-4747 or 645-4753

Questions on AIDS

The Journal for February 1986 had a number of flaws typical of the way the news media have dealt with the AIDS problem. We are sorry to see *The Journal* fall into that mode.

The cover illustrated Transfusion Associated AIDS (TAA) in a sensational manner reminiscent of the "eye catching" cartoon-editorial in the daily *USA Today,* in which a patient was being transfused from a cobra disguised as a blood bag.

The lead article[1] in *The Journal* continued the inaccurate reporting, albeit in a more scientific vein. In the abstract it is stated that the routine screening of donors for anti-HTLVIII/LAV is "currently being instituted" for U.S. blood donors. The truth of the matter is that testing had been in place already for ten months. The difference between May 1985 and February 1986 is an important and volatile error.

The authors mention the risk factor for transfusion in Haiti and the Dominican Republic, but then go on to state in their abstract that "studies of the seroprevalence of HTLVIII/LAV should be conducted to determine the need for monitoring blood donors in this country as well." Since they have just said that the monitoring was being done in the U.S., what are those "studies?" The body of the article does not tell us, and the thought does not resurface until the exact same words are repeated in the last sentence of the paper.

The authors emphasize that the two patients they describe with TAA were living in other countries, were transfused in those other countries and came to Florida only after they became ill. Are those patients going to appear in the CDC registry as Florida TAA? Is Florida the fourth highest state for all varieties of AIDS cases because the reporting has included all of the AIDS cases coming to Miami from the Caribbean for diagnosis and treatment? The authors seem to have fallen into that trap because they state that the majority of TAA cases "receive transfusion" in New York, California, New Jersey or Florida. The reporting on AIDS cases does not include the state of source of the donor blood and therefore, the information in the article is not available.

The problem of TAA is serious. No one is more alarmed or dedicated to its eradicated than the blood bankers. It should be noted that a patient with AIDS who does not have one of the other "known" risk factors but has been transfused, can become listed accidentally as having TAA. That will happen because at least 250,000 people are transfused in Florida each year. Carrying that risk back five years for incubation and allowing for both repeat transfusions and the age of Florida's population, it is obvious that 10% of Florida's people have a history of transfusion. The authors have updated their article to January 6, 1986 with 263 cases of TAA in the United States. On that date there were also 598 cases[1] of AIDS with no known risk. How many of the latter cases would be added to the count of TAA if they also happened to be one of the 10% of people who have been transfused?

We urge readers to adopt a critical view of AIDS reports, not only in the lay press but also in *The Journal.* In the matter of TAA there is more useful information advice in the statement of the Governor's Task Force on AIDS which also bears the date of January 6, 1986:

> "The risk of acquiring HTLV-III through blood transfusion is virtually eliminated with the present HTLV-III antibody screening test and continued use of self-exclusion criteria for high risk donors. There is no risk to donors, and never has been."

References

1. Pitchenik, A.E.; Spira, T.J., and Schiff, E.R.: Acquired Immunodeficiency Syndrome (AIDS) Associated with Blood Transfusion: Review of Literature and Report of Two Cases from Dominican Republic and Haiti. J. Fla. Med. Assoc. 73:107-110, 1986.
2. CDC: Update: Acquired Immunodeficiency Syndrome — United States. MMWR 35:17-21, 1986.

Paul J. Schmidt, M.D., Director
German F. Leparc, M.D., Associate Medical Director
Southwest Florida Blood Bank, Inc.
Tampa

Authors' response • In referring to our article, Drs. Schmidt and Leparc make several statements which are either incomplete, presented out of context or wrong.

Drs. Schmidt and Leparc are correct in pointing out that the abstract of our paper should have stated that HTLVIII/LAV serology "is currently instituted for blood donors in the United States" rather than "is currently being instituted" (the latter statement was true however, when the paper was written). He fails to point out that in both the introduction and conclusion of our paper it states that "screening of blood donors for HTLVIII/LAV is now done routinely in the United States."

Drs. Schmidt and Leparc also quote our article out of context. Since there was little or no data available on HTLVIII/LAV infection or AIDS in the Dominican Republic and no previous cases of transfusion associated AIDS in Dominicans, we stated that there is a need to study the seroprevalence of HTLVIII/LAV in the Dominican Republic on which to base and justify a decision for routinely screening all blood donors in "this country." It stated clearly both in the abstract and concluding paragraph of our article that we felt there was already sufficient evidence to justify the routine screening of all blood donors in Haiti.

Neither of the patients in our article was counted as a case of transfusion associated AIDS in the United States. The first patient had onset of an AIDS related illness two years after arriving in Florida but a history of her having recieved blood transfusions was not obtained at that time. She was therefore counted as a case of AIDS from the United States with no identifiable risk factors. The second patient was counted as a case of transfusion associated AIDS from the Dominican Republic because she was living there at the onset of her AIDS related illness. It is true that regardless of immigrant status, patients with AIDS are included in the United States count by CDC if they are residing in the United States at the time of onset of illness which results in the diagnosis of AIDS. Nevertheless, our article correctly states that "among those transfusion associated AIDS cases reported in more detail, the majority of patients received transfusions in New York, California, New Jersey or Florida." As stated, this referral to cases "reported in more detail" by the CDC[1] to whom information regarding sources of donor blood in these transfusion associated AIDS cases was available. Although initial reporting of transfusion associated AIDS cases to CDC does not include where the transfusions were administered, this information is routinely obtained in follow-up of cases. Drs. Schmidt and Leparc are therefore in error when they state that this "information in the article (i.e. source of donor blood) is not available."

We agree with Drs. Schmidt and Leparc that readers should adopt a critical view of AIDS reports in journals and would extend this recommendation to include correspondence relating to such reports. We also agree in emphasizing that blood transfusions in the United States are virtually safe with respect to risk of HTLVIII/LAV infection now that HTLVIII/LAV antibody screening of blood donors is routinely carried out and that there is and never has been a risk to blood donors. The point of our article was that such screening (if not yet instituted) might also increase the safety of blood transfusions in other countries.

Reference

1. Curran J.W.; Lawrence, D.N.; Jaffe H., et al: Acquired Immunodeficiency Syndrome (AIDS) Associated with Transfusions. N. Engl. J. M., 310:69-75, 1984.

Arthur E. Pitchenik, M.D.
Miami
Thomas J. Spira, M.D.
Atlanta, Georgia
Eugene R. Schiff, M.D.
Miami

Editor's comments: I do not share the view that the cover illustration was sensational in any manner and feel that it was done in as subdued a manner as possible to symbolize one potential way of transmission of the disease.

Hormones and breast cancer

Having practiced medicine for forty-odd years, most of them doing general surgery, I feel that experience should give one a license to meander about a subject that seems to be common knowledge, but may not be as obvious as it appears. I am referring to breast carcinoma which appears in patients who are taking or have recently been taking female hormones (estrogen and/or progesterone) either for birth control or treating postmenopausal conditions.

Some younger physicians may not be aware of the treatment of metastatic breast carcinoma before the advent of chemotherapy. About the only thing available in the 60's and before, except x-ray treatment, was Diethylstilbesterol (DES), a synthetic estrogen quite effective often for months or years as palliation for breast metastases. I have seen x-ray evidence of metastases that completely disappeared for years, only to return at a later date, either spontaneously or because the DES was discontinued. DES was also used for postmenopausal symptoms such as hot flushes and acted clinically the same as natural estrogens so commonly used today as well as in the past.

I first observed a patient in 1968 who had bilateral breast carcinoma presenting as vague caking of the breasts which appeared about ten days after discontinuing birth control pills. The masses did not feel like the usual malignancy. Mammograms were negative, but admittedly were not of the best quality in 1968. Subsequent biopsies revealed bilateral breast carcinoma with bilateral axillary metastases.

Since 1968, I have observed 18 additional cases of women who were taking estrogens and/or progesterone who developed breast carcinoma. The findings are extremely interesting. In many cases the abnormalities in the breast appeared suddenly, almost overnight and were very extensive. Others would appear as a massive lesion involving most of the breast, but with few or no metastatic lymph nodes. Others appeared with relatively small lesions, but with from one to twenty metastatic lymph nodes.

A great number of the patients observed had mammograms which did not show a lesion, or the lesion was seen, but was interpreted as benign. One mammogram showed a 2x3cm lesion with carcinoma characteristics, but the physical involvement was a typical carcinoma measuring 10-12cm. One other patient had two mammograms, no lesion being seen, though a lesion was felt even by the radiologist and subsequent surgery confirmed carcinoma with two lymph nodes showing metastases.

Literature on breast carcinoma often hints that estrogen may stimulate breast carcinoma to rapid growth, but my observations would suggest just the opposite. Could it be that estrogens have been blamed for the rapid growth of breast carcinoma, when in reality it is just the opposite, the hormones causing the carcinoma to mimic normal breast tissue and go undetected either by physical examination or mammogram?

I wonder how many patients found to have breast carcinoma after negative mammograms were patients who were regularly taking estrogens and/or progesterone. I wonder if any physician other than this author interrupts hormone therapy in all patients who present for breast examination, checking the patient at one and two month intervals before resuming the hormones. If an abnormality appears during this time, regardless of mammogram findings, a biopsy is indicated. Often this abnormality appears as a vague, benign-feeling mass, not as the usual hard fixed lesion.

I would like to hear from other physicians who may have seen breast cancer with unusual history and physical findings in patients who were receiving hormones. I also hope this correspondence will stimulate research regarding hormone influence on breast cancer that appears in a patient who at the time is taking female hormones.

Marvin G. Burdette, M.D.
Winter Haven

Malpractice — listening to the voices

Two interesting developments have occurred in the public debate over medical malpractice. The first is a practical matter. In a period of less than a year the medical literature has largely stopped referring to the "malpractice crisis." It is now the "liability crisis." This is a realistic change, as physicians vs lawyer-legislators continues to be a losing battle for physicians. Linkage of our crisis with those of small businessman, day-care centers, municipalities, etc. may well prove to be a more viable approach to obtaining effective legislative relief from the most flagrant abuses of the current adversarial approach.

The second development is the increasingly strident discussion of the failure of the medical profession to protect the public from negligent or incompetent physicians. In a major *New York Times* Op-Ed article published February 2, 1986, the president of the New York City Council made this statement: "Our society has allowed the medical profession to become a priesthood, answerable only to itself. . .The crisis will not be solved by legal reform or by limiting the amount a victim can collect from an insurance company. It can only be solved by disciplining the doctors guilty of negligent care." In a subsequent editorial (February 9, 1986) the *Times* commented that "doctors' agitation will sound self-serving until they permit more rigorous supervision of their profession." Conceding that the the courts and legal system were also performing poorly, this editorial went on to conclude that "instead of appearing to run from accountability, doctors and hospitals ought to be its strongest proponents." One month later (March 9, 1986) the *Times* returned to this topic in a Russell Baker column: "Taking the Hipporcratic Oath buttons their lips under a code of silence as ironbound as those governing the Mafia and the police force."

Closer to home, Jacksonville's *Florida Times-Union* ran wire service story on March 16, 1986 entitled "Billing case illustrates the shaky frame of

medical references." This article included comments from an array of spokesmen who freely acknowledged serious problems in the area of written references. The same paper subsequently (March 24, 1986) published a letter from a medical malpractice victim's group, opposing tort reform and quoting statistics on iatogenic illness.

These five examples occurred in just two newspapers, in the space of only sixty days. While hardly an unbiased or comprehensive review, they do indicate the willingness of politicians and the media to investigate the manner in which the medical profession regulates itself. They also suggest that we have a large credibility gap in this area. The Executive Vice President of the AMA, James Sammons, M.D., responded to the February 2 *Times* article with a letter (*New York Times* February 23) that was less than hard-hitting. Although he made some good points, he admitted that ". . .the medical profession will grant that medical discipline of incompetents through the official system leaves something to be desired." Perhaps the money we are spending to sway legislators might be put to better use — establishing a review process that we do not have to apologize for. Public trust cannot be legislated. Its loss would be greater than the cost of our insurance premiums. The full trust of the public would be worth far more in an effort to achieve legislative reforms than any sum we could raise for a specific campaign.

Stephen Sandroni, M.D.
Jacksonville



The Phone Company For Your Car.

We've put more phones in more cars than anyone in the Southeast. And for an incredibly affordable price, we can put a phone in your car, too.

Our car phone isn't complicated or scary. It's just a phone. With the features and service you're used to getting with your home phone. Only this one goes 55 miles per hour. So call BellSouth Mobility today for full details. **1-800-351-3355.** Because all the way from Jupiter to Florida City, we really are the phone company for your car.

BellSouth Mobility

A *BELL*SOUTH Company

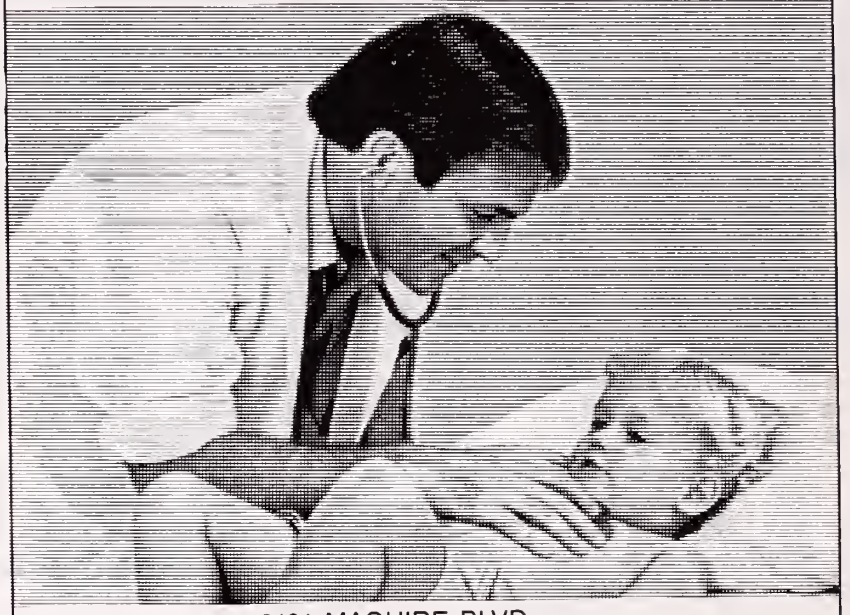
©1986 BellSouth Mobility

PHYSICIANS, WE SCHEDULE OUR TIME TO FIT YOUR TIME.

We're very flexible in the Army Reserve about time. We take into account your practice, your time and availability.

We're not flexible about the quality of medicine. We demand much of ourselves and of every member of our medical team.

If you'd like to learn more about the medical opportunities in a nearby Army Reserve unit, call your Army Medical Personnel Counselor:



3101 MAGUIRE BLVD.
ESSEX BLD., SUITE 166
ORLANDO, FL 32803
CALL COLLECT: (305) 896-0780

ARMY RESERVE. BE ALL YOU CAN BE.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
MAY 1986 Vol. 73, No. 5

Meniere's Disease

John H. Isaacs Jr., M.D., George T. Singleton, M.D. and Michael Mokris, M.D.

ABSTRACT: In 1861 Prosper Meniere described the disease which bears his name and its classic components: tinnitis, hearing loss and vertigo. Since then the symptoms have been gradually clarified and defined and slow advances in understanding the pathophysiology have come about. The disease is believed to be due to an over production or under absorption of endolymph.

The diagnosis is not difficult and should not be made without evidence of fluctuating hearing, tinnitis and vertigo.

Various medical treatments have been tried and are successful in reducing symptoms only about 70% of the time. Treatment is difficult to evaluate because of exacerbations and remissions which are characteristic of the natural course of Meniere's disease. Surgical intervention is also difficult to evaluate. Procedures designed to save the hearing and control the dizziness are successful in 70% of those who do not respond to medical treatment.

The disease can be crippling as well as difficult to treat. Research is progressing slowly. One should not hesitate to refer the patient to an otolaryngologist should this disease be suspected.

The Authors
JOHN H. ISAACS JR., M.D.
GEORGE T. SINGLETON, M.D.
MICHAEL MOKRIS, M.D.
Dr. Issacs is Assistant Professor, Dr. Singleton is Professor, and Dr. Mokris is with the Division of Otolaryngology, Head and Neck Surgery, University of Florida College of Medicine, Gainesville.

In 1861 Prosper Meniere in a series of articles and in a presentation before the Paris Academy of Medicine described the disease which now bears his name. The symptoms include recurrent attacks of acute vertigo and hearing loss with associated nausea and vomiting occurring at intervals from hours to years but leaving the patient free of symptoms between episodes except for a slowly progressive neurosensory hearing impairment. The impairment involves primarily the low frequencies. Meniere also noted the third classic complaint of tinnitus in the affected ear. He was the first to state the site of the lesion was the inner ear but had no concept of the true pathology.[1]

In this paper we discuss the diagnosis of Meniere's disease including the newer diagnostic techniques, the natural history of the disease and its eventual burnout. Pertinent anatomy is reviewed as well as theories of the pathophysiology. Finally, both medical and surgical treatment is described primarily as performed at the University of Florida College of Medicine.

Diagnosis • It is of the utmost importance to be aware that all dizziness is not Meniere's disease. Diagnosis of this disease is very specific and is based upon the triad of episodic vertigo, proven fluctuating hearing loss, and tinnitus associated with the episodes. There is sometimes a fourth symptom, aural fullness. With each episode the patient generally is severely dizzy for 15 minutes to two hours. There is frequently associated nausea and vomiting. The patient will sleep as the attack ends and awaken much refreshed and free of vertigo. If a hearing test is obtained within 48 hours of the episode, a diminution of hearing will be noted which will improve with time.

Early in the course of Meniere's disease, the patient may present with only one symptom; thus making the diagnosis impossible. Fluctuant hearing loss alone will demonstrate the configuration of a low tone neurosensory hearing loss. This is characteristic of early hydrops and will lead one to suspect the diagnosis. There can also be episodes of dizziness alone. One may only suspect the diagnosis based upon any symptom occurring alone. It is impossible to make the diagnosis from the first full blown attack though it may be suspected. One must demonstrate the episodic nature of the vertigo and prove the association of fluctuant hearing loss.

If in the course of the disease one is having difficulty proving the fluctuating nature of the hearing loss, a glycerol test may prove helpful. Glycerol 1.2 ml/kg is given by mouth with equal volume of liquid and a few drops of lemon juice or other flavoring. Hearing is tested before administration and at one and two hours after. A positive test is an improvement of 10 dB or greater of speech reception threshold or of pure tone testing at two or more frequencies, and/or an improvement in understandability of 12% or more.

There can be positional nystagmus and/or spontaneous nystagmus in any direction in association with an Meniere's attack. Nystagmus is more readily seen by using Frenzel glasses. These are 20 diopter lenses enhanced by lights under the lenses which prevent the patient from fixating when used in a darkened room but allow the examiner to visualize the eyes.

Natural history • With each episode of Meniere's disease, hearing gets worse and then gradually improves to almost the preattack level. Thus, over time there is a gradual stepwise decrease in hearing. The frequency of attacks can vary from two to three per day to one every 15 years.

Early in the course of the disease the hearing loss is limited to low tones. With time the loss becomes flat across the frequency spectrum. As the patient gets older, there is a sloping high frequency loss of superimposed presbycusis.

Eventually the disease burns out leaving the patient without vertigo but with a permanent hearing loss of about 60 dB with understandability of about 70%. It seems that the time required for a patient to reach this end point is related primarily to the number and severity of the attacks and not the duration of the disease. As the disease burns out, there is also marked diminution of caloric responses.

Bilateral disease makes treatment much more difficult and has more serious long-term implications for the patient. Because of the inherent problems with bilateral disease, more such patients will be referred to tertiary centers and, thus, such centers will see a higher percentage. Consequently their statistics are not entirely representative of the true incidence. It is generally believed that in over 10% of patients with Meniere's disease the process will become bilateral though the time period for this to occur is variable.

Anatomy and physiology • The anatomy of the inner ear and temporal bone is essentially a bony labyrinth (cochlea, vestibule and three semicircular canals) with a smaller though similarly shaped membranous labyrinth suspended inside. The membranous labyrinth contains endolymph with high potassium and low sodium levels. Perilymph surrounds the membranous labyrinth and is continuous with CSF, thus perilymph has high sodium and low potassium.

Endolymphatic hydrops is a histological diagnosis in which there is an irregular ballooning or blistering of the membranous labyrinth. It is known that endolymphatic hydrops occurs in response to a number of insults and that one of these pathological states is Meniere's disease. It is theorized that in the patient with Meniere's disease an attack occurs when one of these blisters ruptures; there is a sudden movement of membranes which causes dizziness, in addition to the endolymph and perilymph mix, resulting in neurosensory hearing loss without significantly damaging the hair cells. There are several theories as to the cause of hydrops but it is generally believed to be secondary to overproduction and/or underabsorption of endolymph.[2]

There are two rare forms of Meniere's disease. Patients with Lermoyez syndrome note improvement as opposed to the usual decrease in hearing associated with the vertigenous episode. This is likely related to endolymphatic ruptures limited to the vestibular portion of the inner ear. The otolithic catastrophe of Tumarkin is a variation of Meniere's disease in which patients suffer sudden drop attacks without vertigo or loss of consciousness. These episodes are thought to be related to herniation of endolymphatic walls such that they strike or distort the utricular maccula.

The inner ear structures have been found to contain high levels of carbonic anhydrase[3] which has been shown in other systems, particularly the eye and choroid plexuses, to be intimately involved with the production of fluid. The carbonic anhydrase containing cells are thought to be involved in the production of endolymph; the exact mechanism is not clearly understood but probably an electrolyte pump is involved. These cells also contain high levels of sodium and potassium adenosine triphosphatase (ATPase). It is thought that these are important in maintaining the cation gradients and energy potentials found in the endolymph.[4] The presence of carbonic anhydrase forms the basis for some of the medical treatments which will be further discussed.

Medical treatment • The most important fact concerning medical treatment for Meniere's disease is that almost all treatments, medical or surgical, have

approximately 60% to 80% efficacy. The exception is surgical destruction of the labyrinth which in almost 100% of cases cures the vertigo, however, it also causes complete hearing loss.

Much of the medical treatment of Meniere's disease has been aimed at controlling the fluid of the endolymphatic spaces. Salt restriction has been tried by Furtenberg.[5] However, patients find this regimen very difficult to follow and, even when placed on such a diet in the hospital, the results are variable. At the University of Florida, we tend to use diuretics particulary carbonic anhydrase inhibitors, Diamox® and Neptazane® (acetazolamide and methazolamide). The patients are also treated symptomatically with antivertigenous agents particularly meclizine which has been shown to have the best effect of all such agents.

Kidney stones have occurred with Diamox®. Patients with such a history are given Neptazane®. Recently, we have also tended to give Neptazane® more frequently because it is possible to give larger doses with fewer side effects.

Niacin and other vasodilators have been used in the assumption that vasospasm may result in hypoxia to the labyrinth. However, increase in cochlear blood flow has not been demonstrated and these drugs have been shown to be essentially valueless.

Occasionally, in an effort to break frequent attacks, histamine can be used. The disadvantage is that it can only be given parenterally. The usual treatment at the University of Florida is to place 2.75 mg of histamine acid phosphatase base in 200 cc of normal saline and to infuse once a day while carefully monitoring the patient's vital signs. The treatment is repeated for three days and it must be given to the point of flush but short of headache. This appears to be effective for short term control when attacks are so frequent that they prevent normal lifestyle. Droperidol may be used to abort severe attacks and offer short term reprieve. It requires careful, continuous monitoring.

Surgical treatment ● In most treatment regimens, surgery is reserved for medical failures. Despite this, surgical treatments appear to have, again, a 60% to 80% success rate with the exception of the destruct labyrinthian procedures. There are multiple surgical treatments and this in itself points to the fact that none has proved highly successful in curing vertigo and preserving hearing.

Endolymphatic shunt operations are based on the assumption of elevated endolymphatic pressure and that decompression will alleviate symptoms. The theoretical advantage is preservation of hearing. Shunts have been placed in the subarachnoid space or the mastoid cavity with little difference in operative results. This operation came into general use in the 1960s[6,7] and since that time several modifications have been proposed from simple incision of the sac to placement of tubes into the sac for drainage in the subarachnoid space or mastoid cavity. Temporalis muscle flaps are brought into the area in hopes of increasing the vascularity and thus enhancing resorption. It appears that with this operation over five years hearing may be stabilized. However, a large double blind study shows little difference between a placebo operation of simple mastoidectomy and shunt procedure.[8] At the present time there is controversy about the efficiency of shunt procedures. On young patients generally with bilateral hearing loss and a positive glycerol test and who also have serviceable hearing, we will try an endolymphatic procedure. Complications of sac procedures include complete loss of hearing, cerebrospinal fluid otorrhea, otic hydrocephalus, shunt tube occlusion, labyrinthitis, and meningitis.

We have recently started performing cochleostromies which is a benign procedure with a lower incidence of neurosensory hearing loss than prior drainage procedures such as the Cody-Tack operation. It is used only if serviceable hearing is present. However, Schunknecht reports a high rate of hearing loss; this may be due to persistent fistula of the round window.[2]

Occasionally, if the aforementioned treatments fail, an ultrasound destruction of the labyrinth will be done. This treatment is particularly useful in young patients with bilateral disease. It is neither beneficial nor detrimental to hearing. There is approximately 20% incidence of temporary facial paralysis; we believe this is probably due to the presence of approximately 20% incidence of dehiscent facial nerve in the middle ear space.

Destructive labyrinthectomies include transmastoid semicircular canal drillouts, horizontal canal fistulization and transtympanic labyrinthectomies. These should be 99% effective in controlling vertigo and are used on patients with useless hearing or patients whose ability to work and function is so severly limited by disease that they are willing to give up hearing in one ear in order to be free of symptoms.

While vestibular nerve section has been advocated by many, at the University of Florida we tend to avoid it because of the severity of complications, particularly brainstem strokes and permanent facial paralysis, loss of hearing and CSF fistula.

Conclusions ● The diagnosis of Meniere's Disease demands the triad of fluctuating hearing loss, episodic vertigo, tinnitus, and is supported by the fourth component aural fullness. Care should be exercised to avoid missing other more treatable diagnoses such as early acoustic neuroma or perilymph fistula. Most medical treatments will result in improvement in approximately 70% of cases. At the University of Florida and at most centers, surgical treatment is used only after medical treatment. Both medical and surgical treatment is tailored to the individual patient's needs.

References

1. Harker, L.A. and McCabe, B.F.: Meniere's Disease and Other Peripheral Labyrinthine Disorders. In: Otolaryngology, Paparella and Shamrock (eds.), Philadelphia, W.B Saunders Company, 1980, p. 1978.
2. Schunknecht, H.F.: Pathogenesis and Pathology of Meniere's Disease, workshop on unresolved research problems in Meniere's Disease, ARO Abstracts, January 1982.
3. Erulkar, S.D. and Maren, T.H.: Carbonic Anhydrase and Inner Ear, Nature 189(4763):459-460, 1961.
4. Maren, T.H.: Cerebrospinal Fluid Aqueous Humor and Endolymph. In: Medical Physiology, Mountcastle, V.B. (ed.), St. Louis, C.V. Mosby Company, 1980.
5. Furtenberg, A.C.; Lashmet, F.H., and Lathrop, F.: Meniere's Symptom Complex: Medical Treatment, Ann. Otolaryngol. Rhinol. Laryngol. 43:1035, 1984.
6. House, W.F.: Subarachnoid Shunt for Drainage of Hydrops: Report of 63 Cases, Arch. Otolaryngol. 79:338-354, 1964
7. House, W.F.: Subarachnoid Shunt for Drainage of Hydrops: Report of 146 Cases, Laryngoscope 75:1547-1551, 1965.
8. Bretlau, P.; Thomsen, J.; Tos, M., and Johnson, N.J.: Placebo Effect in Surgery for Meniere's Disease: A Double Blind Placebo Controlled Study in Endolymphatic Sac Shunt Surgery, Symposium on Vestibular Neurotology, Universite de Montreal, September 1980.

- Dr. Isaacs, Division of Otolaryngoly — Head and Neck Surgery, Box J-264, JHMHC, University of Florida College of Medicine, Gainesville 32610.

Posttransfusion purpura — a rare manifestation of blood transfusion

Muhammad Saeed, M.D., F.A.G.S., and Charles E. Barrineau, M.D., F.A.C.S.

ABSTRACT: An 85-year-old gravada V, para v, female presented with upper gastrointestinal bleeding. Physical examination was unremarkable except skin pallor and faint wheezing in chest. Platelet count was 218,000/ul. Packed red cells were administered because of anemia. On the sixth day of transfusion the platelet count dropped to 2,000/ul. Anti-PL^{A1} antibody was detected in the serum. The platelets lacked PL^{A1} antigen. Prompt response was noted to intravenous steroids (Solu-Cortef) with rise in the platelet count and cessation of bleeding. Blood transfusion during steroid administration did not affect the beneficial effect and no recurrence of thrombocytopenia was noted.

The Authors
MUHAMMAD SAEED, M.D., F.A.G.S.
CHARLES E. BARRINEAU, M.D., F.A.C.S.
Dr. Saeed, a hematologist at Putnam Community Hospital, Palatka, and Dr. Barrineau, a General Surgeon at Putnam Community Hospital, are both private practitioners in Palatka.

Posttransfusion purpura (PTP) is a rare heterogeneous syndrome occurring mostly in females whose platelets usually lack PL^{A1} antigen. Severe thrombocytopenia is noted five to ten days after transfusion of blood or blood products. Different modes of therapy have been described including exchange blood transfusion, plasmapheresis, and steroids with variable results.

We report a case of PTP in which systemic corticosteroids not only promptly reversed severe thrombocytopenia but transfusion of packed red cells (unwashed) during treatment did not alter the beneficial effect of the steroids. Follow-up showed a progressive decline in antiplatelet antibody level in the serum.

Case report • An 85-year-old white female was admitted to the hospital on 5-4-85 because of gastrointestinal bleeding. She was gravida V, para V, and had not received a blood transfusion in the past. Her only major medical problem was bronchial asthma for 50 years which had been treated intermittently with bronchodilators. She had been hospitalized on several occasions because of severe respiratory insufficiency. For two weeks prior to the present admission she had taken tolmetin sodium (Tolectin) off and on for arthritic pain in the ankles and knees. There was no history of allergic disorder or hemorrhagic tendency. Physical examination revealed a pale female looking acutely ill. Occasional faint wheezing was heard in the chest. No abdominal tenderness or rigidity was elicited. There was no hepatosplenomegaly or palpable abdominal masses. Examination of the skin and mucous membranes did not reveal purpura or ecchymosis. No acutely inflamed joints or joint effusion were noted.

Laboratory data • At the time of admission, white cell count was 8.5 x 10^3; hemoglobin 7.8 gm/dl; hematocrit 22.9% and platelets 218,000/ul. Prothrombin time and partial thromboplastin time were normal. Her blood group was A Rh positive. Anti-

nuclear antibody and LE cell preparation were negative. Chest x-ray showed chronic obstructive pulmonary disease with fibrosis. Upper GI endoscopy revealed multiple acute erosive ulcers in the stomach.

Treatment • Medical treatment was begun including intravenous Tagamet. Several units of packed red cells were given over the course of several days starting 5-4-85 because of intermittent gastorintestinal bleeding and a drop in hemoglobin and hematocrit. On 5-10-85 the platelet count was noted to be 2,000/ul. She was given two units of packed red cells, one unit of fresh frozen plasma, and ten units of platelet concentrate with only a slight and temporary increase in the platelet count (16,000/ul). Repeat partial thromboplastin time was normal. On 5-11-85 pyloroplasty and vagotomy were performed with closure of bleeding points and gastrostomy tube insertion for feeding. However, GI bleeding persisted and more transfusions of packed red cells were given along with fresh frozen plasma and platelet concentrates. There was a febrile response with some joint aching with each transfusion of platelet concentrates which responded promptly to diphenhydramine hydrochloride (Benadryl). A peripheral smear revealed severe thrombocytopenia, leukocytosis with shift to the left and normocytic-normochromic red blood cells. Bone marrow was cellular and megakaryocytes were adequate. Anti-PL^{A1} antibody was detected in serum by immunofluorescence flow cytometry and her platelets were negative for PL^{A1} antigen. On the 11th hospital day, treatment with intravenous hydrocortisone sodium succinate (Solu-Cortef) was begun. Between 5-14-85 and 5-17-85 a total of 700 mg were given intravenously with prompt increase in the platelet count. On 5-17-85 two units of unwashed packed red cells were infused. No drop in platelet count was noted. She was discharged from the hospital on 5-29-85; her platelet count at the time was 250,000/ul. The gastrostomy tube had been removed and GI bleeding had completely stopped. No evidence of purpura of the skin or mucous membranes was noted during the entire hospital stay. On 10-1-85 the platelet count was 293,000/ul and antiplatelet antibody in the serum showed more than 50% decrease antiplatelet antibody was undectable in serum on 2-17-86 (Fig. 1).

Discussion • Posttransfusion purpura is an acute heterogeneous syndrome. It consists of immune thrombocytopenic purpura which occurs as an anamnestic response six to ten days after tranfusion of blood or blood products. First observed by Van Loghem et al[1] and Zucker et al[2] in 1959, Shulman et al[3] noted association between thrombocytopenia and platelet alloantibodies in two cases in 1961. About 30 cases have been reported so far;[4] all but two have been females (39-78 years)[5,6] previously sensitized by blood transfusions or pregnancies. Platelet alloantibodies are directed against platelet PL^{A1} antigen. Patients in whom PTP develops lack PL^{A1} antigen on their platelets. Platelet PL^{A1} antigen is present in 98% of the population and while 2% lacks this immunological determinant, why PTP is so rare is unknown. Occasional patients with positive platelet PL^{A1} antigen in whom PTP develops have been described[5] and must, therefore, have an antibody against another antigen system. Vaughan et al published a case of PTP caused by anti-PL^{B1} antibody.[7]

At present it is not clear how the alloantibody can destroy PL^{A1} negative platelets. Two mechanisms have been proposed. (a) The innocent bystander hypothesis suggests that anti-PL^{A1} antibody production is stimulated by PL^{A1} positive platelets which combines in turn with PL^{A1} antigen to form immune complexes. These immune complexes are eluted off or released from donor platelets to bind to the patient's platelets to cause their nonspecific destruction;[3] (b) Cross reaction of anti-PL^{A1} antibody with another platelet antigen.[8] Additional factors may be involved in thrombocytopenia because repeat blood transfusion in some patients with PTP may not result in increased antibody production or thrombocytopenia.[9] Thrombocytopenia may persist up to seven weeks in untreated patients or those treated with steroids.

Different methods of therapy have been employed with variable results. Shulman et al[3] and Cimo and Aster[10] used whole blood exchange transfusion in two of their patients with complete recovery within 72 hours. Plasma exchange has been used by others with success[9,11-13] although it was totally unsuccessful in one patient.[14] Plasma exchange probably helps by removing platelet antigen, antibody, or immune complexes. As the antibody is of IgG type with large extravascular distribution, plasma exchange may have to be repeated several times. Platelet transfusions with PL^{A1} positive or PL^{A1} negative platelets fail to raise the platelet count because they are rapidly destroyed.[15] Steroids have been used in some cases with success[6,12] while in others they failed to improve platelet count. In such cases, combined use of steroids and plasma exchange may accelerate recovery.[12].

Our patient, an 85-year-old female previously sensitized by several pregnancies, is a classic case of PTP. Severe thrombocytopenia developed six days after the first transfusion of packed red cells. However, she failed to manifest other symptoms of thrombocytopenia (such as purpura) and persistent GI bleeding was attributed to gastric ulcers, and probably dilutional thrombocytopenia because of several blood transfusions. Transfusion of platelet concentrates increased the platelet count only slightly and temporarily possibly because of their rapid destruction by antiplatelet antibody. However, there was prompt response to relatively small doses of systemic steroids with cessation of bleeding and rise in platelet count.

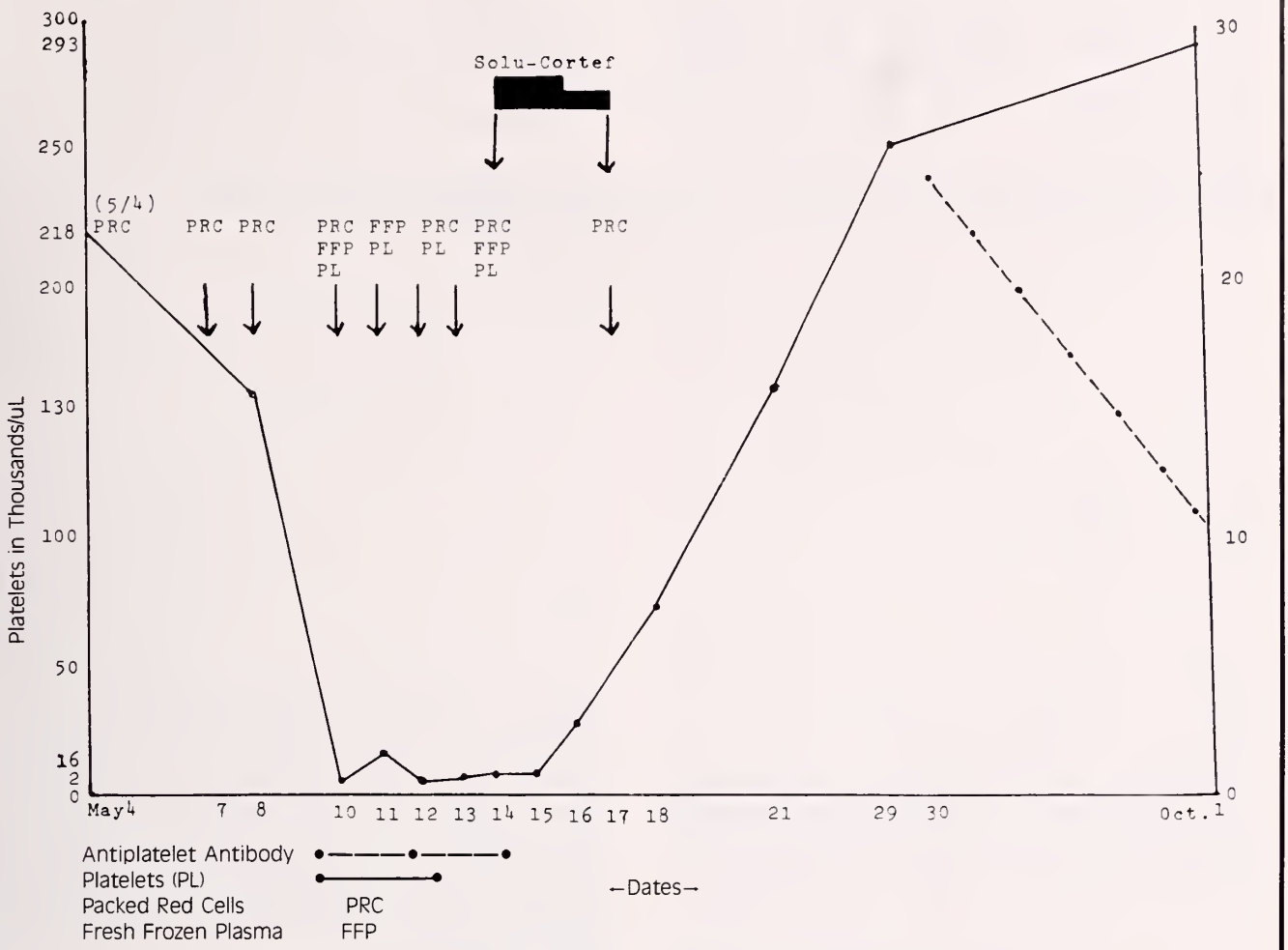


Fig. 1 — Antiplatelet Antibody (Mean Flourescence Intensity Per Platelet)

Packed red cell transfusion during treatment with steroids failed to reverse the recovery and is compatible with observation of Lau et al.[9] Antiplatelet antibody in serum has completely disappeared. We feel that use of steroids is a reasonable approach to treatment of PTP, but the therapeutic failure may necessitate plasma exchange.

Acknowledgment

The authors are grateful to Diane Reed and Betina Garner for their help in preparing this manuscript.

References

1. Van Loghem, J.J.; Dorfmeijer, H., and Van der Hart, M.: Serological and Genetical Studies on a Platelet Antigen (ZW), Von Sang 4:161-169, 1959.
2. Zucker, M.B.; Ley, A.B.; Borrelli, J.; Mayer, K., and Firmat, J.: Thrombocytopenia with Circulating Platelet Agglutinin, Platelet Lysin and Clot Retraction Inhibitor, Blood 14:148-161, 1959.
3. Shulman, N.R.; Aster, R.H.; Leitner, A., and Hiller, M.C.: Immunoreactions Involving Platelets. V. Posttransfusion Purpura Due to Complement-Fixing Antibody Against Genetically Controlled Platelet Antigen: Proposed Mechanism for Thrombocytopenia and Its Relevance in "Autoimmunity," J. Clin. Invest. 40:1597-1620, 1961.
4. Williams, J.W. and Aster, R.H.: Thrombocytopenia Due to Enhanced Platelet Destruction. Hematology (Ed. 3) 1298-1325, 1983, McGraw-Hill Book Co. New York.
5. Ziegler, Z; Murphy, S., and Gardner, F.H.; Posttransfusion Purpura: Heterogeneous Syndrome, Blood 45:529, 1975.
6. Seidenfeld, A.M.; Owen, J., and Glynn, M.F.X.: Posttransfusion Purpura Cured by Steroid Therapy in a man, Canad. M. A. J. 118:1285, 1978 (technical note).
7. Vaughan, Neil E.F.; Arderman, S., and Bevan, G.: Posttransfusion Purpura Associated with Unusual Platelet Antibody (anti-PL^{B1}). Br. Med. J. 1:436, 1975.
8. Morrison, F.S. and Mollison, P.L.: Posttransfusion Purpura, New England J. M. 275:243-248, 1966.
9. Lau, P.; Sholtis, M., and Aster, R.H.: Posttransfusion Purpura: Enigma of Alloimmunization, Am. J. Hematol. 9:331-336, 1980.
10. Cimo, P.L. and Aster, R.H.: Posttransfusion Purpura: Successful Treatment with Exchange Transfusion, New England J. M. 287-290. 1972.
11. Abramson, N.; Eisenberg, P.D., and Aster, R.H.: Posttransfusion Purpura: Immunological Aspects and Therapy, New England J. M. 291:1163-1166, 1974.
12. Rhadke, P.K. and Isbister, J.P.: Posttransfusion Purpura, Med. J. Aust. 1:430-432, 1980.
13. Eisenberg, P.D. and Abramson, N.: Posttransfusion Purpura Revisited, New England J. M. 296:515-516, 1977 (letter).
14. Erichson, R.B.; Viles, H.; Grann, V., and Ziegler, Z.: Posttransfusion Purpura: Case Report with Observation on Antibody Detection and Therapy, Arch. Intern. Med 138:998, 1978.
15. Gerstner, J.B.; Smith, M.J.; Davis, K.D.; Cimo, P.L., and Aster, R.H.: Posttransfusion Purpura: Therapeutic Failure of PL^{A1} Negative Platelet Transfusion, Am. J. Hematol. 5:71, 1979.

● Dr. Saeed, Putnam Community Hospital, Palatka 32077.

Severe post-TURP syndrome in patient with renal insufficiency: treatment with hemofiltration

Stephen Sandroni, M.D.

ABSTRACT: Severe hyponatremia, volume overload, and coma occurred in a 71-year-old man with advanced renal insufficiency who underwent transurethral prostatectomy (post-TURP syndrome). The patient did not respond to diuretics. Hemofiltration with normal saline replacement rapidly corrected the volume overload and more gradually corrected the hyponatremia with resolution of the coma.

Transurethral resection of the prostate is not infrequently complicated by hyponatremia. In some patients there is severe hyponatremia and altered mental status including coma. Patients with renal insufficiency may be at increased risk and more difficult to treat. This report presents a patient with renal insufficiency in whom severe hyponatremia, volume overload, and coma occurred. Treatment using hemofiltration is described and the etiology of the hyponatremia and altered mental status in this setting is reviewed.

Case report ● A 71-year-old man with advanced renal insufficiency (BUN 81, creatinine 7.6) underwent transurethral prostatectomy. He was alert and euvolemic with serum sodium of 139 mEq/1 prior to surgery. The procedure was uneventful. Anesthesia was general. Postoperatively the patient did not regain consciousness and his serum electrolytes revealed sodium at 110 mEq/1.

The patient appeared to be in a volume overloaded state postoperatively and had no apparent response to intravenous furosemide. It was decided to treat him with hemofiltration using normal saline as replacement fluid. Vascular access was obtained via a previously unused Cimino fistula. A Gambro FH 101 hemofilter was used in conjunction with a blood pump. Systemic heparinization was monitored by bedside determinations of activated clotting times.

Blood pump speed and a clamp in the filtrate effluent line maintained filtrate formation at about 1,200 ml per hour, estimated from graduated cylinder collections of filtrate every 15 minutes. Replacement volumes of normal saline were administered to match the filtrate volume. Over a seven hour period 8,400 ml of filtrate were removed with replacement of 7,200 ml of normal saline. The serum sodium rose to 126 mEq/1 in this period for a rate of correction of 2.3 mEq/1 per hour. Blood pressure was well maintained throughout and there was no evidence of any bleeding problem. The patient became more responsive after the third hour and gradually regained full consciousness.

An initial period of hemofiltration without saline replacement was used to alleviate severe pulmonary congestion and isolated hemofiltration was necessary for periods

The Author
STEPHEN SANDRONI, M.D.
Dr. Sandroni is Assistant Professor of Medicine at the University of Florida College of Medicine and is also the attending nephrologist at University Hospital in Jacksonville.

of about 20 minutes three other times to correct worsening pulmonary congestion as judged by tachypnea and chest auscultation. The serum ammonia level was not elevated. The measured serum osmolality was 278 at the start of treatment; a simultaneous calculated effective osmolality was 230.

Comments • Transurethral resection of the prostate (TURP) is generally performed using large volumes of 1.5% glycine solution as an irrigant. A number of complications have been described known as the post-TURP syndrome. This includes hyponatremia, altered mental status, hypoosomolality, and rarely death. Hyponatremia occurred in 8.8% and 19% of patients in two series.[1,2] The absorption of fluid during this procedure has been studied and an average of 889 ml was absorbed by a group of 34 patients during TURP for benign prostatic disease.[3] About one third of the fluid is absorbed from spaces surrounding the prostatic capsule through defects in the capsule or the bladder. Technical suggestions to minimize hydrostatic pressure in the prostatic fossa have been made as this is considered an important determinant of absorption.[3]

The occurrence of coma following TURP is uncommon but well documented. In one series of 78 hyponatremic post-TURP patients, 14 or 18% deteriorated into a comatose or semicomatose state. These were older patients with longer resection times and serum sodium less than 120 mEq/1 postoperatively.[4] The coma has been ascribed in the past to acute dilutional hyponatremia and perhaps subsequent cerebral edema.[4,5] More recently this view has been challenged by authors[6] who propose a more complex mechanism. Based on the fate of both absorbed glycine and water, they propose that the post-TURP syndrome depends on one or all of these factors: (1) dilutional hyponatremia not accompanied by severe hypoosmolality because absorption of osmotically active glycine occurs; (2) acute water intoxication; (3) direct neurotoxicity from glycine or its metabolites. Several patients have been reported with hyperammonemia in this setting[7,8] although this was not observed in one series.[9] Dissociation between CNS symptoms and evidence of volume overload[6] also supports the concept of a multifactorial etiology for the altered mental status of the post-TURP syndrome.

Although data are not available regarding the number of patients with renal insufficiency undergoing TURP, the number is likely to increase given general gains in longevity as well as improved survival of patients with renal insufficiency. We have had three such patients at our institution in the past year. Such patients may have increased susceptibility to the post-TURP syndrome with diminished ability to excrete a full water load.

Treatment of the post-TURP syndrome has been based on administration of small amounts of hypertonic saline as well as diuretics. Use of the hemofilter allowed us to stabilize this present patient's volume status rapidly and isoosmotically and to subsequently correct his hyponatremia at a rate associated with low morbidity.[10] We used the hemofilter in conjunction with standard dialysis blood lines, blood pump, and monitors for purposes of safer monitoring for clotting and air leaks and to allow rapid generation of filtrate. With regard to the etiology of coma in this setting we did not find increased serum ammonia but did note an "osmolar gap" (measured osmolality — calculated osmolality) when we initiated therapy, supporting the concept that absorbed glycine may have been present in this patient.

References

1. Fitzpatrick, J.M.; Kaidas, G.P., and Rose, G.A.: Hyperoxaluria Following Glycine Irrigation for Transurethral Prostatectomy, Br. J. Urol. 53:250-252, 1981.
2. Desmond, J.: Complications of Transurethral Prostatic Surgery, Can. Anaesth. Soc. J. 17:25-36, 1970.
3. Oester, A. and Madsen, P.: Determination of Absorption of Irrigating Fluid During Transurethral Resection of Prostate by Means of Radioisotopes, J. Urol. 102:714-719, 1969.
4. Henderson, D. and Middleton, R.: Coma from Hyponatremia Following Transurethral Resection of Prostate, Urol. 15:267-271, 1980.
5. Wakim, K.: Pathophysiologic Basis for Clinical Manifestations and Complications of Transurethral Prostatic Resection, J. Urol 106:719-728, 1971.
6. Zucker, J. and Bull, A.: Independent Plasma Levels of Sodium and Glycine During Transurethral Resection of Prostate, Can. Anaesth. Soc. J. 31:307-313, 1984
7. Ruesch, R.; Stoelting, R.; Lingeman, J., et al: Ammonia Toxicity Resulting from Glycine Absorption During Transurethral Resection of Prostate, Anesthesiology 58:577-579, 1983.
8. Ryder, K.; Olson, J.; Kahnosk, R., et al: Hyperammonemia After Transurethral Resection of Prostate, J. Urol. 132:955-997, 1984
9. Madsen, P. and Madsen, R.: Clinical and Experimental Evaluation of Different Irrigating Fluids for Transurethral Surgery, Invest. Urol. 3:122-129, 1965.
10. Ayus, J.; Krothapalli, R., and Arieff, A.: Changing Concepts in Treatment of Severe Symptomatic Hyponatremia, Am. J. Med. 78:897-902, 1985.

• Dr. Sandroni, University Hospital, 655 West 8th Street, Jacksonville 32209.

Severe post-TURP syndrome in patient with renal insufficiency: treatment with hemofiltration

Stephen Sandroni, M.D.

ABSTRACT: Severe hyponatremia, volume overload, and coma occurred in a 71-year-old man with advanced renal insufficiency who underwent transurethral prostatectomy (post-TURP syndrome). The patient did not respond to diuretics. Hemofiltration with normal saline replacement rapidly corrected the volume overload and more gradually corrected the hyponatremia with resolution of the coma.

Transurethral resection of the prostate is not infrequently complicated by hyponatremia. In some patients there is severe hyponatremia and altered mental status including coma. Patients with renal insufficiency may be at increased risk and more difficult to treat. This report presents a patient with renal insufficiency in whom severe hyponatremia, volume overload, and coma occurred. Treatment using hemofiltration is described and the etiology of the hyponatremia and altered mental status in this setting is reviewed.

Case report ● A 71-year-old man with advanced renal insufficiency (BUN 81, creatinine 7.6) underwent transurethral prostatectomy. He was alert and euvolemic with serum sodium of 139 mEq/1 prior to surgery. The procedure was uneventful. Anesthesia was general. Postoperatively the patient did not regain consciousness and his serum electrolytes revealed sodium at 110 mEq/1.

The patient appeared to be in a volume overloaded state postoperatively and had no apparent response to intravenous furosemide. It was decided to treat him with hemofiltration using normal saline as replacement fluid. Vascular access was obtained via a previously unused Cimino fistula. A Gambro FH 101 hemofilter was used in conjunction with a blood pump. Systemic heparinization was monitored by bedside determinations of activated clotting times.

Blood pump speed and a clamp in the filtrate effluent line maintained filtrate formation at about 1,200 ml per hour, estimated from graduated cylinder collections of filtrate every 15 minutes. Replacement volumes of normal saline were administered to match the filtrate volume. Over a seven hour period 8,400 ml of filtrate were removed with replacement of 7,200 ml of normal saline. The serum sodium rose to 126 mEq/1 in this period for a rate of correction of 2.3 mEq/1 per hour. Blood pressure was well maintained throughout and there was no evidence of any bleeding problem. The patient became more responsive after the third hour and gradually regained full consciousness.

An initial period of hemofiltration without saline replacement was used to alleviate severe pulmonary congestion and isolated hemofiltration was necessary for periods

The Author
STEPHEN SANDRONI, M.D.
Dr. Sandroni is Assistant Professor of Medicine at the University of Florida College of Medicine and is also the attending nephrologist at University Hospital in Jacksonville.

of about 20 minutes three other times to correct worsening pulmonary congestion as judged by tachypnea and chest auscultation. The serum ammonia level was not elevated. The measured serum osmolality was 278 at the start of treatment; a simultaneous calculated effective osmolality was 230.

Comments • Transurethral resection of the prostate (TURP) is generally performed using large volumes of 1.5% glycine solution as an irrigant. A number of complications have been described known as the post-TURP syndrome. This includes hyponatremia, altered mental status, hypoosomolality, and rarely death. Hyponatremia occurred in 8.8% and 19% of patients in two series.[1,2] The absorption of fluid during this procedure has been studied and an average of 889 ml was absorbed by a group of 34 patients during TURP for benign prostatic disease.[3] About one third of the fluid is absorbed from spaces surrounding the prostatic capsule through defects in the capsule or the bladder. Technical suggestions to minimize hydrostatic pressure in the prostatic fossa have been made as this is considered an important determinant of absorption.[3]

The occurrence of coma following TURP is uncommon but well documented. In one series of 78 hyponatremic post-TURP patients, 14 or 18% deteriorated into a comatose or semicomatose state. These were older patients with longer resection times and serum sodium less than 120 mEq/1 postoperatively.[4] The coma has been ascribed in the past to acute dilutional hyponatremia and perhaps subsequent cerebral edema.[4,5] More recently this view has been challenged by authors[6] who propose a more complex mechanism. Based on the fate of both absorbed glycine and water, they propose that the post-TURP syndrome depends on one or all of these factors: (1) dilutional hyponatremia not accompanied by severe hypoosmolality because absorption of osmotically active glycine occurs; (2) acute water intoxication; (3) direct neurotoxicity from glycine or its metabolites. Several patients have been reported with hyperammonemia in this setting[7,8] although this was not observed in one series.[9] Dissociation between CNS symptoms and evidence of volume overload[6] also supports the concept of a multifactorial etiology for the altered mental status of the post-TURP syndrome.

Although data are not available regarding the number of patients with renal insufficiency undergoing TURP, the number is likely to increase given general gains in longevity as well as improved survival of patients with renal insufficiency. We have had three such patients at our institution in the past year. Such patients may have increased susceptibility to the post-TURP syndrome with diminished ability to excrete a full water load.

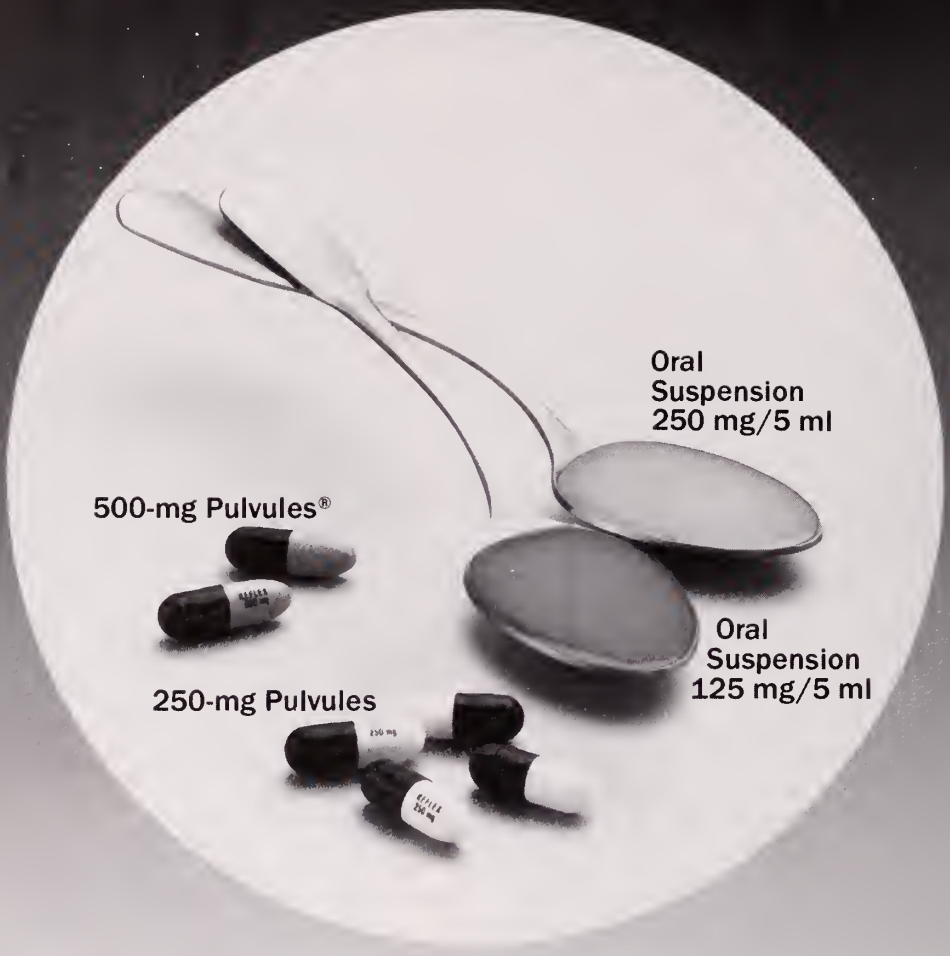
Treatment of the post-TURP syndrome has been based on administration of small amounts of hypertonic saline as well as diuretics. Use of the hemofilter allowed us to stabilize this present patient's volume status rapidly and isoosmotically and to subsequently correct his hyponatremia at a rate associated with low morbidity.[10] We used the hemofilter in conjunction with standard dialysis blood lines, blood pump, and monitors for purposes of safer monitoring for clotting and air leaks and to allow rapid generation of filtrate. With regard to the etiology of coma in this setting we did not find increased serum ammonia but did note an "osmolar gap" (measured osmolality — calculated osmolality) when we initiated therapy, supporting the concept that absorbed glycine may have been present in this patient.

References

1. Fitzpatrick, J.M.; Kaidas, G.P., and Rose, G.A.: Hyperoxaluria Following Glycine Irrigation for Transurethral Prostatectomy, Br. J. Urol. 53:250-252, 1981.
2. Desmond, J.: Complications of Transurethral Prostatic Surgery, Can. Anaesth. Soc. J. 17:25-36, 1970.
3. Oester, A. and Madsen, P.: Determination of Absorption of Irrigating Fluid During Transurethral Resection of Prostate by Means of Radioisotopes, J. Urol. 102:714-719, 1969.
4. Henderson, D. and Middleton, R.: Coma from Hyponatremia Following Transurethral Resection of Prostate, Urol. 15:267-271, 1980.
5. Wakim, K.: Pathophysiologic Basis for Clinical Manifestations and Complications of Transurethral Prostatic Resection, J. Urol 106:719-728, 1971.
6. Zucker, J. and Bull, A.: Independent Plasma Levels of Sodium and Glycine During Transurethral Resection of Prostate, Can. Anaesth. Soc. J. 31:307-313, 1984.
7. Ruesch, R.; Stoelting, R.; Lingeman, J., et al: Ammonia Toxicity Resulting from Glycine Absorption During Transurethral Resection of Prostate, Anesthesiology 58:577-579, 1983.
8. Ryder, K.; Olson, J.; Kahnosk, R., et al: Hyperammonemia After Transurethral Resection of Prostate, J. Urol. 132:955-997, 1984.
9. Madsen, P. and Madsen, R.: Clinical and Experimental Evaluation of Different Irrigating Fluids for Transurethral Surgery, Invest. Urol. 3:122-129, 1965.
10. Ayus, J.; Krothapalli, R., and Arieff, A.: Changing Concepts in Treatment of Severe Symptomatic Hyponatremia, Am. J. Med. 78:897-902, 1985.

• Dr. Sandroni, University Hospital, 655 West 8th Street, Jacksonville 32209.

Easy To Take



Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA

420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

SPECIAL ARTICLE

Physician payment plans and conflicts of interest

Richard J. Feinstein, M.D.

For physicians, the subject of conflicts of interest involves the myriad and almost daily dilemmas in which their loyalty to the patient is divided among loyalties to other interests, including their own. Ancient philosophers and historians wrote of such conflicts thousands of years ago after observing the practice of physicians within their own society. In his now famous oath 2500 years ago, Hippocrates cautioned physicians to be careful to avoid exploiting patients for the physicians' good. This same oath is sworn to by many contemporary medical school graduates before being handed their medical degree from an official of their school.

Plato observed that doctors who took care of slaves were less attentive and devoted to their patients than doctors who provided medical care to free men.[1] That ancient conflict arose in large measure because physicians to slaves owed their basic loyalty to the payer of the medical care, the slave owner. It is also likely that physicians received a discounted fee for providing care to slaves. Some physicians in ancient Greece were slaves themselves.

Doctors who cared for free men, like most physicians today, sought to attract as many paying patients as possible and to make their fee seem just by not only delivering excellent medical care but by also treating their patients with respect and dignity. Plato observed that doctors of free men allowed patients to participate in decisions about their own care, while doctors to slaves spoke little and ordered care for these patients without comment or explanation.

In health care systems that pay direct fee-for-service, the patient enters into a contractual arrangement with his physician to pay for medical care. It is the only medical payment system which leaves physicians completely free to act in their patients' best interests, while not jeapordizing their own interests in any way. In a perfect fee-for-service system, the physician is unfettered by cost restraints and has completely free access to all the best medical and surgical modalities available. He will do all that is necessary to treat his patient properly. Although he may sometimes overutilize the resources available to him, he is capable of adjusting to financial constraints as they arise in the real but imperfect world, by learning how to be more cost effective in his goal of providing high quality medical care. Moral satisfaction is obtained for having been able to do all that is possible for his patient, without guilt or conflicts of interest. The payment system encourages hard work and diligence and a concern for not only the patients' health but financial welfare as well, since the patient must pay directly from his pocket for all costs incurred.

A second payment system utilizes salaried physicians, and it is theoretically possible for physicians to avoid conflicts of interest in a system where they are salaried employees of a health care corporation as long as they are allowed to provide whatever care they feel is necessary for their patients without economic restraints or reprisals for perceived or real overutilization of expensive resources. Such economic freedom for salaried physicians, who have lost complete con-

The Author
RICHARD J. FEINSTEIN, M.D.
Dr. Feinstein is Clinical Associate Professor of the Department of Dermatology of the University of Miami School of Medicine, Miami.

trol of health care delivery by virtue of their employment is hardly ever possible. The owner-payer of the health plan, be it the Federal or state government, a corporate board of directors, or a single wealthy businessman, will tend to favor those physicians who keep costs down and utilize expensive modalities infrequently.

Economic and other pressures by health care owners toward their salaried physicians employees to be cost effective and to underutilize health care resources tends to coerce doctors into a conflict of interest dilemma where they may be forced into seeking out their own interests by performing less services for patients, so that the physician can be recognized by his employer as being efficient and worthy of promotion and bonus. The salaried physician assumes the economic goals of the corporation and likes it, places corporate economic interests ahead of his patients need for medical care.

A third kind of health care payment system involves the retrospective reimbursement of independent physicians by health insurance companies or other third parties. This has been the most prevalent payment system for the past twenty or more years, and is employed by most health insurance companies to reimburse physicians for their services to beneficiaries. In an ideal situation, the physician is reimbursed retrospectively in a fair way for providing medical care to his patient, and he is allowed to do whatever is necessary for his patient while understanding that he will receive a reasonabale payment for the services he has rendered within a reasonable period of time.

The salaried physician assumes the economic goals of the corporation and likes it, places corporate economic interests ahead of his patients need for medical care.

Third party payment plans have no physician conflicts of interest as long as the payer of the care does not place his own economic interests ahead of the doctors' desire to do all that is possible for the patient. Of course real life is almost never ideal and there are always economic pressures placed by third parties on their physician providers. The degree of freedom given to a competent physician to provide care for his patient is the matter of greatest concern in the third party retrospective payment system.

It is perfectly reasonable for third party payers to make certain taht their money is being wisely spent and to reduce waste and fraud. It is not reasonable, however, for third party payers to retroactively deny payment for services already rendered by physicians who were never provided with adequate warning of a policy change or a reasonable chance to evaluate and react to written policy changes of the payer. It is also not reasonable for payers to autocratically order physicians to provide care in very restricted ways, which may not allow the variations of treatment style so often demonstrated by different competent physicians.

Third parties, including Congress, often make economic concerns of paramount importance without understanding that such actions may jeapordize the ability of the physician to act in behalf of his patient, without becoming involved in a conflict of interest and jeapordizing the patients' health.

The fourth and least ethical form of health care payment system, I believe, is the prospective prepayment or capitation system. It creates the greatest potential for conflicts of interest by pitting the natural inclinations of the physician to act in his patients' behalf against the authority of the payer-owner of the HMO or other health plan, to restrict services and make profits. The physician's economic interests are completely separated from his desire to treat his patients properly.

There is no problem in those HMOs which pay their physicians a salary or by fee for service, even if the amount paid is significantly reduced from usual charges, because the physician's desire to do all that is necessary for his patient is also rewarded by additional payments for his increased intellectual and/or physical efforts.

A conflict of interest almost always arises when the physician's economic interests are pitted against his desire to help his patient. Almost all physicians have a strong natural desire to help their patients or they would not have become doctors in the first place, and almost all physicians view their patients' interests as their most important goal. Prospective payment systems, as utilized by certain HMOs, which pay their physicians a prospective flat amount, often in the form of a monthly capitation allowance, to provide health care for a patient, have created a system in which the altruism of the physician is stressed beyond reasonable levels. If a family practitioner, for example, is given $100 a month for taking care of each Medicare patient assigned to him, and many of these patients become sick enough to require laboratory studies, referral to specialists, and special studies that must be paid from his monthly capitation allowance, his desire to provide adequate care for his patients will be pitted against his desire to prevent economic loss and the possible bankruptcy of his medical practice. He will have a conflict of interests that no physician should ever be exposed to.

Although Medicare only began participating in HMOs on a capitation basis two years ago, there are already numerous examples of physicians on capitation from one or more of Florida's HMOs who have gone bankrupt because they could not manage their practice on the monthly stipend alloted to them by the parent organization. There are also examples of HMO physicians who have been charged by the state

medical or osteopathic disciplinary board with having failed to provide their patients with the proper medical and/or surgical care that a reasonably prudent physician would have provided under similar circumstances. It is believed that their failure to refer to specialists, order required tests or other procedures, had a purely economic motivation.

I believe that we are just beginning to see situations in which physicians will be faced with a dramatic conflict of interests because of their association with health organizations which capitate payments to them. More and more physicians will succumb to pressures to favor their own economic interests and survival over the patients' interest and desire for quality medical care.

It is not an idle notion that humans try harder when their own interests are best served through hard work, diligence and the pursuit of excellence.

Medicare will create a somewhat analogous situation of conflict when doctors' services are inclued in DRG payments. The physician will receive a flat amount for providing medical services to a particular patient. The physician may be expected to pay consultants and possibly even the hospital from his DRG allotment, forcing him to consider his own economic welfare when contemplating medical services that may be required by his patient.

Under physician DRGs, the amount of medical care required by a patient in certain situations will make the fixed payment from Medicare fall far below the minimum wage, rendering it virtually meaningless. Hopefully, physicians will continue to have enough income from other Medicare patients and from patients who pay directly or who have other forms of health care insurance, to accomodate the financial burden and conflict of interests produced by these few patients. The average physician provided $18,090 worth of free service in 1985 and physicians have always seen certain patients for free or for reduced payment, but they have been able to afford to do so because the majority of their other patients pay for their medical care.[2]

The wisdom of history shows that direct payment of fee for medical service has existed for thousands of years. Patients paid the shaman, medicine man or early doctor with goods, services, or cash, in exchange for receiving medical care. Almost all other transactions in our society utilize the direct payment of cash in return for the delivery of goods or services. It is not an idle notion that humans try harder when their own interests are best served through hard work, diligence and the pursuit of excellence. They also have more respect for their client and his money when he is paying directly for goods of services received. The new systems of health care payment, utilizing prospective and fixed payments, which pits the physician's self-interests against his natural inclinations to help his patients, augurs poorly for the future of health care in this nation, and for the well-being of the nation itself.

References

1. Heagarty, M.C., and Robertson, L.S.: Slave Doctors and Free Doctors — A Participant Observer Study of the Physician — Patient Relation in a Low-Income Comprehensive-Care Program, NEJM Vol. 284, No. 12, Mar. 25, 1971, pgs. 636-641.
2. AMA Newsletter. American Medical News, Feb. 21, 1986, pg. 8.

● Dr. Feinstein, M.D., 3661 S. Miami Ave., Miami 33133.

Medical eye care by optometrists: retrospective review 1977-1983

Waite S. Kirkconnell, M.D., F.A.C.S., Tully C. Patrowicz, O.D., M.S., M.D., and Ronald W. Case, M.D., F.A.C.S.

For the past twenty years the optometric profession has been involved in a concerted effort to extend the scope of its professional practice beyond the traditional refractive services to include diagnosis and treatment of eye disease. Legislative testimony by optometrists and optometric journals state that optometrists are fully qualified to diagnose and treat eye disease. Their claim to that position is based upon the following premises:

1. That there are no malpractice judgements against optometrists.
2. There are no negligence complaints filed with State Boards of Optometry.
3. The optometric use of diagnostic eyedrops results in an inconsequential complication rate.
4. Optometric training programs now include appropriate pharmacological teaching to qualify the recent graduate to undertake medical diagnosis and treatment.
5. The older practicing optometrists can update their education to permit the use of pharmacologic agents.

The following Retrospective Care Review identifies and documents medical conditions which may arise as a result of this expanded optometric practice.

The Authors
WAITE S. KIRKCONNELL, M.D., F.A.C.S.
TULLY C. PATROWICZ, O.D., M.S., M.D.
RONALD W. CASE, M.D., F.A.C.S.
Dr. Kirkconnell is Associate Professor, Dr. Patrowicz is Clinical Assistant Professor, and Dr. Case is Clinical Assistant Professor of the Department of Ophthalmology at the University of South Florida.

Methods and materials • For many years, Florida ophthalmologists have submitted to the Florida Society of Ophthalmology individual case reports of clinically serious medical conditions arising from the efforts of all health practitioners to diagnose and treat ocular conditions. The reporting ophthalmologist is the only individual identified by name on this form (Fig. 1). Each ophthalmologist has maintained his own records and has developed his own individual code for identifying these case reports. All but two of these reports involve optometrists. Only the optometric cases are being reviewed in this study. The individual case reports are currently on file with the office of the Florida Society of Ophthalmology.

The current Florida Optometric Practice Act, written in 1939, contains language that in the contents of the Medical Practice Act, written in 1931, was interpreted to exclude drugs and surgery from the practice of optometry. However, the 1939 language, taken out of its original context and removed from Attorney General's opinions, as well as case law, is ambiguous and permissive. In 1975, the Florida State Board of Optometry authorized Florida optometrists to use diagnostic and therapeutic eyedrops. Since that time, Florida optometrists have begun treating ever increasing numbers of conditions that had been previously referred.

The following examples were selected because they are typical of the broad range of medical conditions involved in this review.

Case No. 1 • A 57-year-old female with known chronic obstructive pulmonary disease was started on Timolol by an optometrist. When the patient became dyspneic, her internist discontinued the Timolol, and advised the patient to consult an ophthalmologist. The patient returned to the optometrist who simply restarted the Timolol, producing an

Fig. 1. — Referral Evaluation Form

Physician's Name _____

Address: _____

Patient Information:

Age _____ Sex _____ Race _____

Condition of Health: Good _____ Fair _____ Poor _____

Medical Diagnosis: _____

The patient said he/she had been seen by (O.D., M.D., A.R.N.P., etc.) in _____ on or about _____ and the following transpired:

Approximate date of optometric graduation: Before 1965 ☐ After 1965 ☐ Don't Know ☐

If the patient was seen by an O.D., did he/she think they were an M.D.? Yes ____ No ____

The patient claims that no medical referral was made: Yes _____ No _____

The patient claims that he was referred for the following: _____

This case appears to be a problem of:

Failure to refer _____ Misdiangosis _____

False reassurance _____ Unnecessary treatment _____

Improper treatment _____ Other _____

Explanation:

exacerbation of the disease. A subsequent evaluation by an ophthalmologist found that she had ocular hypertension not requiring therapy.

Case No. 2 ● An 18-year-old male construction worker was struck in the right eye while hammering. He consulted an optometrist and was told that he had a scratched cornea and was given an antibiotic ointment. The ocular pain persistesd and the patient consulted the optometrist again and was reassured. Two days later the patient reported the injury to his employer and was referred to an ophthalmologist who diagnosed a perforation of the cornea, lens, and vitreous. Immediate eye surgery was required.

Case No. 3 ● A 57-year-old female had been seen annually by the same optometrist for 15 years. She complained of decreased central visual acuity and loss of peripheral vision. Frequent changes of glasses did not alleviate her symptoms. An ophthalmologist found that she had far advanced glaucoma that had caused legal blindness. The patient instituted a malpractice suit against her former optometrist, which was settled out of court.

Case No. 4 ● A 59-year-old female who was seen by an optometrist and complained of a curtain over the inner part of her left eye of approximately 6 weeks duration. She was advised by the optometrist after his examination that there was nothing wrong with her eye. She subsequently consulted an ophtholomogist who found that she had a retinal detachment with macular involvement in her left eye. Although the retina was successfully reattached by a scleral buckling procedure, the patient did not obtain a full return of her central visual acuity. The patient filed a malpractice suit against the optometrist which is pending in the circuit court.

Case No. 5: ● A 23-year-old male was struck in the left eye by a racquetball. His loss of central visual acuity cleared over a few minutes but floaters and flashing lights persisted. He was examined by an optometrist and was told that his

only problem was "floaters." He advised the patient to resume his usual activities which consisted of a vigorous physical activity. Two weeks later the patient awoke to realize that he had lost much of his visual field in the injured left eye. He consulted the optometrist two days later and was immediately referred to a vitreoretinal surgeon who diagnosed a giant retinal tear with massive retinal detachment in the injured eye. Multiple surgical procedures were necessary to reattach the retina resulting in a best corrected visual acuity of 20/400 and a dilated nonresponsive pupil in the injured eye. He sued the optometrist and the case was settled two weeks prior to trial.

Case No. 6 ● A 53-year-old male was given an antibiotic ointment by his optometrist for an "eye infection" in his left eye. When the eye failed to respond, the optometrist discontinued the antibiotic ointment and started the patient on artificial tears. No ophthalmic referral was suggested. When the pain intensified and the visual acuity fell on the third day, the patient contacted an ophthalmologist. The visual acuity was reduced to finger counting. A severe uveitis with glaucoma and a central retinal vein occlusion was diagnosed. The patient's visual acuity was permanently reduced to counting fingers at six feet.

Case No. 7 ● A 70-year-old diabetic female was referred by her internist for an evaluation of her retinopathy in 1982. She was noted to have a moderate background diabetic retinopathy with a few isolated areas of neovascularization. A vitreoretinal surgeon elected to follow this retinopathy at four month intervals. Subsquently the patient was informed by this ophthalmologist that there had been some minimal progression of the retinopathy in the right eye, and advised her to return in four months with the admonition that laser treatment might be necessary. One month later she received a recall card from the optometrist who had changed glasses two years previously. After the optometric examination she was told that nothing could be done for the right eye and that she did not need to be seen again for two years. She did not seek further ophthalmologic care until seven months later at which time she was seen as an emergency with end stage neovascular hemorrhagic glaucoma which required a retrobulbar alcohol injection of the right eye.

Case No. 8: ● A 70-year-old male was treated by an optometrist for a painful red eye of two days duration in August, 1983. The patient's eye did not respond to decongestant eyedrops. New glasses were prescribed. After two weeks the patient contacted a family practitioner who referred the patient to an ophthalmologist. Two weeks of treatment with a topical antiviral agent healed the dendritic ulcer; however, the patient was left with advanced stromal scarring and vision decreased to 20/200.

Case No. 9 ● A 26-year-old female was treated by an optometrist for a red eye with a topical antibiotic steroid combination drug. When she did not respond, the optometrist referred her to an internist who admitted her to a hospital with a diagnosis of lupus erythematosis. After four days of extensive, negative testing, she was discharged with no improvement in her ocular condition. She then consulted an ophthalmologist who initiated treatment for keratoconjunctivitis which promptly responded.

Case No. 10 ● A 65-year-old female who after cataract surgery in both eyes in 1965 had successfully worn extended wear contact lenses fitted by her optometrist. After a routine contact lens cleaning by the optometrists's assistant, she developed bilateral ocular irritation. The assistant referred the patient to an ophthalmologist who treated the patient for a corneal abrasion in the left eye and bilateral keratoconjunctivitis. The optometrist noted that the left eye was irritated two days after having seen the ophthalmologist and he ". . .felt that in my professional opinion that she needed to have a little something extra to try to clear up the infection in the eye." He treated her with an antibiotic ointment four times a day to be taken in addition to the antibiotic that the ophthalmologist had previously prescribed. The optometrist recommended an optometric follow-up examination in two days. At that time he was unable to state whether the eye "was better or worse." Another ophthalmologist's opinion was sought by the patient on her own recognizance. Immediate and intensive therapy for the painful large central fulminating corneal ulcer was instituted. Although the ulcer ultimately healed, full visual acuity was not restored. A lawsuit was filed and the optometrist was found liable for damages by a jury two years after the incident.

Results ● The results are summarized in Fig. 2. One hundred sixty-three cases were collected from 1977 to 1983. These included five cases of bilateral legal blindness, 22 cases of unilateral blindness, and 38 cases of permanently decreased vision. Diagnoses included 39 cases of glaucoma, 11 corneal foreign bodies, nine cases of herpetic keratitis, eight bacterial corneal ulcers, ten retinal detachments, 15 cases of conjuctivitis, eight case of uveitis, six cases of intraocular tumor, and 16 other medical conditions.

In those patients with glaucoma, the most common error was failure to establish a timely diagnosis. There were instances of ocular hypertension being treated as glaucoma (Case No. 1). Delay in diagnosis was apparent in retinal detachments and intraocular tumors as well.

Although optometrists claim expertise in handling all types of external foreign bodies, including rust rings, this expertise was not demonstrated in this review. Throughout all of these reported cases, failure to recognize serious medical disease and improper treatment were the most common deficiencies. Most case reports involved multiple errors on the part of the patient's optometrist. The six cases of intraocular tumors and twelve cases of glaucoma were producing the symptoms that led the patients to seek medical care from the optometrists. The remainder of the glaucoma cases that were not diagnosed were, in fact, far advanced cases in which the diagnosis was obvious. The retinal detachments in this review were all symptomatic (Cases No. 4 and 5). The other medical diagnoses, encountered in the review, would all have been obvious to any medical practitioner who could have then either initiated treatment or referred the patient to an ophthalmologist.

In 1965, optometry schools added courses in pharmacology and differential diagnosis to their curriculum. Therefore, the age of the optometrist as an indicator of educational background may be significant. Optometrists younger than 40 years of age were more likely to have had exposure to pharmacology, differential diagnosis and didactic interaction in phar-

macology. Fig. 2 indicates the proportion of those above and below age 40. In those cases that involved multiple optometrists, the case is counted only once and the ages of the optometrists are listed separately.

Discussion • In 1954, at the Annual Congress of the American Optometric Association, in Seattle, Washington, the following resolutions were adopted: "Resolve that the field of vision care is and should be exclusively the field of optometry. Throughout the years optometry laws have granted exemptions to certain groups and classes (ophthalmologists). Resolve that these exemptions be restricted, limited, and ultimately eliminated." Since that Congress thirty years ago, the AOA has maintained an ongoing campaign to broaden the scope of optometric practice by removing constraints from the State Optometric Practice Acts, succeeding in the adoption by the Rhode Island Legislature of the first Diagnostic Pharmaceutical Bill in 1971. Since that time, similar statutes have been enacted in forty-five states.

In 1976, a bill allowing optometrists to use topical therapeutic agents was passed in West Virginia. Eleven states now permit the use of therapeutic eyedrops. The Florida Legislature passed legislation which has the effect of giving optometrists the unlimited right to use any type of topical or systemic medication including parenteral administration. This legislation also includes the implied right to do unlimited surgery. This legislation was vetoed by Governor Bob Graham. That veto was challenged in the courts. The Supreme Court of Florida upheld the Governor's veto.

The optometric literature advocates changes in optometric referral patterns: treatment of routine medical problems by optometrists with the referral of complicated cases to tertiary specialists such as vitreoretinal surgeons.

This review cannot indicate the actual index of optometric misadventures since there are no statistics on the number of patients receiving medical treatment from optometrists. Several observations suggest that the actual rate of such unfortunate results may be high.

Only 16 of the 163 cases were referred to ophthalmologists by optometrists, even when it should have been obvious that the patients were not responding to optometric treatment. Thirty-three patients had been referred by optomoterists to non-ophthalmologist M.D.'s or D.O.'s, often with the admonition that no further referral should be made without the approval of the optometrist. These patients were in fact referred to ophthalmologists. The remainder, 114 patients, received no referral at all.

The optometric literature is replete with claims and justifications that optometrists are able to treat medical and surgical conditions. Louis J. Catania, O.D., faculty member of the Pennsylvania State College of Optometry, has written extensively advocating the use of therapeutic medications, systemic medications, and the treatment of most ocular emergencies by optometrists.[1,9] Richard Clompus, O.D., has written "how to" articles complete with illustrations of the probing and irrigation of nasolacrimal ducts and removal of corneal foreign bodies and rust rings.[10,11] Other optometric authors have advocated these and other surgical procedures.[3,12]

Optometrists have been urged to follow their patients with diabetic retinopathy until the optometrists have determined that laser treatment is indicated, at which time they can refer the patient to a vitreoretinal surgeon (not a general ophthalmologist) for follow-up care.[13] A sizeable minority of optometrists object to this broadening of the scope of optometry urging that the profession should emphasize traditional optometric modalities such as refraction, dispensing, visual training, low vision and contact lens fitting.[14,15]

Ophthalmologists have long been cognizant of the optometric failures to diagnose and refer ocular conditions. State Optometric Practice Acts and traditional optometric practice have provided referral guidelines for patients with medical problems. There has been little perceived need by ophthalmologists and other medical practitioners to promulgate errors in diagnosis or treatment by optometrists. Eight cases in this review were reported to the Florida State Board of Optometry. Two cases in the review involved Florida State Board of Optometry members. The data suggest that there is reluctance by ophthalmologists to refer problems of negligence to State Board agencies. Optometrists now regard this paucity of published and reported medical negligence material as a positive indication of their success in the medical care arena. Ophthalmologists are increasingly aware and concerned with this type of spurious reassurance that ostensibly promotes increased medical practice by non-medical practitioners.

The optometric profession is currently having economic difficulties.[1,2,16,17] A recent survey by Irving Bennett, O.D., reports a net gain of ophthalmologists in the United States of 324 per year. By 1990 there will be enough opthalmologists to provide all of the vision and medical eye care now being given by both the present number of optometrists and ophthalmologists.[17] Irving Borish, O.D., notes that optometrists are now receiving unprecendented amounts of competition; they are losing their dispensing business to the optical chains and their refraction and contact lens patients to ophthalmologists.[7] A survey by the California Department of Consumer Affairs affirms this economic plight.[8] A recent survey by *Medical Economics Magazine* shows that the average optometrist experienced a significant increase in both his net and gross earnings from his practice in 1984. This may well be attributable to an acceptance of this expansion in the scope of optometric practice.

		Type of Error (Subjective opinion of reporting ophthalmologists)						Age of Optometrist
Diagnosis	Number	Failure to Refer	False Assurance	Improper Treatment	Mis-diagnosis	Unneces-sary Treat-ment	Other	Below 40
Glaucoma	39	35	28	9	8	3		8
Conjunctivitis	15	14		12	2	4		13
Corneal Foreign Body	11	8	3	9	3	1		5
Retinal Detachments	10	11	10		6	2		3
Herpetic Keratitis	9	9	1	9	7	2		4
Other Corneal Ulcers	8	8		8	3	3		1
Uveitis	8	8		6	6	3		4
Lid Infection	7	7	1	6	2			2
Diabetic Retinopathy	6	7	5	1				1
Contact Lens Complications	6	5	2	5	2			5
Intraocular Tumors	6	6	4	2	3	2		4
Retinal Vascular Disease	5	3		4	2	1		1
Strabismus	5	5		3	2	2	2	2
Cataract	5	5	1	2	3	2		3
Normal	5			4	5	3	2	1
Systemic Disease	4	2		2	2			2
Macular Degeneration	4	1			2			
Symptomatic Brain Tumor	3	2	2	2	1	1		2
Chemical Burns	2	2		2				1
Cerebral Vascular Disease	1	1	1					1
Orbital Disease	1	1		1				1
Bell's Palsy	1			1	1			1
Congenital Abnormality	1			1	1			
Endophthalmitis	1	1	1	1	1			
Totals	163							64

Fig. 2 — 163 Cases First Seen by Optometrists

		Visual Result				Malpractice cases		
Above 40	Unknown	Permanent Impair-ment	Unilateral Blindness	Bilateral Blindness	Referral to State Optometry Board	Filed	Settled	Out of State O.D.'s
30		25	8	2		2	2	1
4					3			
5								
6		1	6			2	1	2
6		4			1			
4		3						
1	2		2		1			2
1								
4		1		1				
1		1						
1			5			2		
4					2			
2					1			
1								
3								
3								
4						1		
1		1		2				
		2						
1		1						
82		38	22	5	8	7	3	5

This current retrospective review is not in accord with the optometric premise that there are no malpractice judgements against optometrists. There were eleven malpractice cases: four have been settled in favor of the plaintiffs and seven are pending. Malpractice litigation has become an increasing problem for optometrists. Guerrin states that there has been a tenfold increase in malpractice premiums in the past ten years and as much as a twentyfold increase is anticipated in the next few years.[18] He advocates that every optometrist do every test on every patient.[18] The leadership of the American Optometric Association tends to play down this malpractice problem. Frequently cited is a 1980 study by the National Association of Insurance Commissioners which found that optometrists have an exceedingly low rate of malpractice. The optometric profession does not mention that this report covers the period from July, 1975, to December, 1978, when the optometrists surveyed were practicing traditional optometry rather than using diagnostic and therapeutic pharmaceutical agents.[19] That study cannot be considered germane to optometrists who engage in medical and surgical modalities. It is unrealistic to compare optometric and ophthalmologic malpractice rates, since most instances of alleged ophthalmologic malpractice involve surgery. The 1980 report of the National Association of the National Insurance Commissioners, so often quoted in the optometric literature, found that ophthalmologists who did no surgery had a malpractice exposure only slightly greater than that of optometrists.[19]

Of the 163 cases, eight were referred to the Florida Board of Optometry. Optometrists in West Virginia and North Carolina claim that there have been no complaints to the respective state regulatory agencies. In fact, over 300 cases have been reported in North Carolina.

In this review there were no complications associated with the use of diagnostic pharmaceutical agents. However, there are numerous diagnostic errors demonstrating an inability to make medical diagnosis. Further, in those cases in which diagnostic drugs were used, there is no evidence that accuracy of diagnoses was improved. The optometrists cite a complication rate of 0.24103% of adverse reactions with diagnostic agents in California.[2] Except for acute angle closure glaucoma, prolonged mydriasis and allergic reactions, most complications of diagnostic pharmaceutical agents are systemic in effect. These effects may elude practitioners untrained in general medical evaluation.

A study by the Nebraska Ophthalmology Society reports that the pharmacology curriculum varies from 30 hours of instruction at the Pacific University College of Optometry, to 204 hours of instruction at the Southern College of Optometry (Nebraska Ophthalmology Society — data compiled from 1983 catalogs from ten schools of optometry). The quality of these courses is subject to question since none of the optometry schools are located in states that permit optometrists to use therapeutic topical or systemic medications(The Oklahoma School of Optometry at Tahlequah, Oklahoma, graduated its first class of 24 students in May, 1983. The Oklahoma legislature changed the Optometric Practice Act to permit the use of any drug, by any means of Administration, in April, 1984). This review did not reveal any significant difference in the medical diagnostic and therapeutic acumen of those optometrists who had received didactic pharmacologic training in optometry school. It is unrealistic to expect any effect from "updating" pharmacology courses for the older optometrists.

This review reveals that serious health consequences are beginning to surface as a consequence of the expanded optometric practice. If optometrists perceive themselves as having less constraints on their being able to practice with the use of drugs and surgery (e.g. Florida Senate Bill 168 — 1983), more optometric attempts to medically diagnose and treat patients will occur. Thus, an ever increasing spiraling pattern will be inevitable with an increase in the frequency of optometric negligence.

Summary • This is a qualitative study that demonstrates the need for a more complete study that would include all medical cases treated by optometrists, preferably supervised by an impartial expert. A retrospective review of case reports was conducted in an effort to examine several optometric premises which are the stated basis for the expansion of the scope of optometric practice into the practice of medicine. These premises appear to be ill-founded. Accepting them leads to significant antithetical conclusions which include misdiagnosis, improper treatment, and delayed referral as is noted in this review. The interference with traditional referral patterns was mentioned. Physicians treating patients who have chosen to entrust their vision care to non-medical practitioners should be alerted to these potential dangers.

References

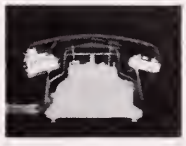
1. Catania, Louis J.: Why We Need Therapeutic Drugs, Review of Optometry, Vol. 120:5, May 1983, pp. 14-15.
2. Guerrein, Richard L.: Editorial, Review of Optometry, 119:7, p. 14.
3. Reed, Keven C.: Management of Corneal Siderosis, Optometric Monthly, Vol. 74:4, April 1983, pp. 181-184.
4. Poweleit, Alvin A.: Optometry's Encroachment Upon Medicine, Ophthalmology Times, March 1981, pp. 4-6.
5. Applebaum, Morris and Jaanus, Siret, D.: A Study on Utilization of Diagnostic Pharmaceutical Incidence and Incidence of Side Effects Observed by Optometrists, Optometric Monthly, Vol. 73:4, April 1982, pp. 197-202.
6. Caleen, R.L. Jr.: Hearing Officer, State of Florida, Division of Administrative Hearings, Case No. 82-1886-R, Florida Medical Association, Florida Society of Ophthalmology, W.J. Broussard, M.D., vs. Florida State Department of Professional Regulation, Florida State Board of Optometry and Florida Optometric Association, Inc., March 22, 1984.
7. Herrin, Stan and Borish, I.M.: Optometry's Idea Man, Review of Optometry, Vol. 119:3, 1982, p. 27.

8. California Department of Consumers Affairs, Division of Consumer Services. Research and Specific Projects Unit 12-31-81. Consumer Practice Restrictions in Optometry.
9. Catania, Louis J.: The Ocular Accident Load, Optometric Management, Vol 19:3, March 1983, pp. 39-41.
10. Clompus, Richard: When the Patient Complains of Excessive Tearing, Review of Optometry, Vol. 120:3, March 1983, p. 51-57.
11. Clompus, Richard: How to Find and Remove Corneal Foreign Bodies, Review of Optometry, Vol. 120-9, 1983, pp. 20-26.
12. Kleinstein, Robert N.: Penetrating Injuries to the Eye, Optometric Monthly, Vol. 73:12, 1982, pp. 680-682.
13. Calderon, Richard M.: Diabeatic Eye, Contemporary Optometry, Vol. 2:1, May 1983, pp. 21-22.
14. Greenberg, Robert M.: Behavior Optometry and Primary Care — Are the Concepts Compatible? Journal AOA, Vol. 54:9, Sept. 1983, pp. 771-773.
15. Peters, Henry: Editorial, The Dog and the Bone, Journal AOA, Vol 47:5, May 1976, pp. 276-277.
16. Guerrein, Richard L.: Editorial, Review of Optometry, Vol. 120:7, 1983, p. 17.
17. Bennett, Irving: Survey of the Eye Care Industry, Optometric Monthly, Vol 74:6, pp. 326-340.
18. Guerrein, Richard L.: Optometric Malpractice, Review of Optometry, Vol. 119:12, 1982, pp. 18 and 29-33.
19. Classe', John G.: Malpractice Claims Abstracted from Report of National Association of Insurance Commissioners, Bulletin from the AOA Interprofessional Concern Project Team, Vol. 39:42, April 10, 1981, pp. 1, 3, and 5.
20. North Carolina Society of Ophthalmology: Optometric Mismanagement Study. Published by North Carolina Medical Society, 222 N. Person St., Raleigh, N.C., 27611, May 1984

● Dr. Kirkconnell, 2919 Swann Avenue, Suite 307, Tampa 33609.



MIST brings our Cardiovascular



The Division of Cardiovascular Disease provides clinical services in all aspects of disease involving the heart and blood vessels. Faculty members within the division present a broad range of special interests and expertise, including:

Cardiac Arrhythmias • Cardiac Angiography • Valvular and Congenital Heart Disease • Coronary Artery Angiography • Ischemic Heart Disease • Hemodynamics • Radionuclide Imaging of the Heart • Holter Monitoring • Electrocardiography • Cardiac NMR • Digital Subtraction Cardiac Angiography • Echocardiography • Coronary Angioplasty • Hypertension • Coronary Artery Thrombolytic Therapy.

The division performs all the traditional as well as the newest diagnostic and therapeutic procedures.

Inpatient services are provided in fifty beds maintained in the University of Alabama Hospitals, including seven in a specifically maintained and



Disease Specialists into your office.

equipped Intensive Evaluation Unit.

The Division of Cardiovascular Disease is one of 41 departments and divisions of the University of Alabama Medical Center accessible to you through Medical Information Service via Telephone (MIST).

By dialing the MIST number you have access to faculty specialists seven days a week, 24 hours a day. Consultation, referrals, and transfers via the Critical Care Transport Service are as close as your phone.

Consult With A Specialist, Call

MIST: **1 800 292-6508** IN ALABAMA
1 800 452-9860 OUTSIDE ALABAMA

UAB The University of Alabama at Birmingham

FAMILY PRACTICE. A REWARDING EXPERIENCE IN ARMY MEDICINE.



The Army has more soldiers with families than ever before. So when you join the Army Medical Team as a Family Practitioner, expect to spend most of your time serving not only soldiers, but their spouses and children, too. What's more, you won't have to worry about the paperwork, malpractice insurance premiums, or the costs incurred in running a private practice.

Expect to work in a highly challenging and varied environment. Working with a team of highly trained professionals, you can receive assignments almost anywhere in the United States; the Army offers the largest system of comprehensive health care in the nation. Family Practice positions are also available overseas, in Germany and Korea.

The benefits package available to Army Family Practitioners is quite attractive. You'll receive 30 days paid vacation, opportunities to continue education and conduct research, a chance to travel, and reasonable work hours.

All in all, your Army Family Practice will be a rewarding experience. Not only for you, but for Army families, too. Talk to your Army Medical Department Counselor for more information.

ARMY MEDICINE
3101 MAGUIRE BLVD.
ESSEX BLD., SUITE 166
ORLANDO, FL 32803
CALL COLLECT: (305) 896-0780

ARMY MEDICINE. BE ALL YOU CAN BE.

Proposals for capitation reimbursement of physician fees

The Health Care Financing Administration (HCFA) is engrossed in discovering new ways of controlling physician fees and reducing Medicare payments to doctors. The interest in constricting payments to physicians has arisen because of the large increases that have occurred in Medicare Part B payments since 1967. In fiscal year 1968 Part B reimbursements amounted to $1.4 billion. By fiscal year 1984 this figure had swollen to $19.5 billion. This figure represents an annual compounded increase of 18% a year. Data collectors and policy makers have mistakenly alleged that this huge increase reflects payments to physicians alone. This is erroneous. In a recent publication, *Payment of Physician Services: Strategies for Medicare,* the authors fail to properly segment the causes of the cost expansion. Nearly 7% is due to inflation; 3% is due to larger numbers of the Medicare eligible patients. There is an ill defined amount that is derived from expenses for new programs that were not covered in 1968 such as renal dialysis, payment to pharmacists for certain equipment, and payment for home health care services. Other Part B costs come from payment to non-physicians such as physical therapists, occupational therapists and chiropractors. Certainly since 1968 the complexity of medical services and increased utilization have also occurred and account for some of the hypertrophy of the Part B Medicare budget cost.

Policy makers, however, are unfairly blaming physicians. In reality most physicians have not profited individually during the Medicare years. The average, inflation — adjusted net income (before taxes but after expenses) of all doctors was $42,700 in 1973 and $40,200 in 1984, a 5.6% decrease. These numbers have been adjusted to 1970 dollars. Certain groups of physicians have economically suffered significantly during the Medicare years. From 1973 through 1983 general practitioners and family physicians observed their income (unadjusted for inflation) increase from $41,900 to $68,500 which is an annual compounded increase of 4.6%. During the same years inflation increased at approximately 6.9% a year. The family physician therefore lost over 2% a year. Superficially this 2% loss per year seems inconsequential. However, it amounts to a significant sum when compounded over the same decade. If family physician-general practitioner income had increased in concert with the inflation rate his 1983 income would have been $87,900 instead of $68,500. This difference represents a 28% decline in actual net income for the family doctor. In contrast anesthesiologists and surgeons have done well. Net income for surgeons increased from $57,400 in 1973 to $145,500 in 1983, an 8.8% increase. The net income for anesthesiologist increased from $48,100 to $144,700, a 10.5% compounded annual increase. Both of these surpassed the inflation rate.

The fairness of the policy advisers' opinions regarding physicians fees and the defects in the data they have collected are not to be debated in this paper. The percept of policy makers is that physician payment mechanisms must be altered, obviously by penalizing all physicians by lowering payments to them. Some form of capitation program appears to be most favored within the Reagan Administration. Officials would like to assign each Medicare beneficiary a voucher which would pay so many dollars of medical care per year. The patient could use that voucher to purchase the services he or she required. The voucher system has been poorly conceived and experimentation with such a plan has not been performed. Its likelihood of success is severely limited.

Advisers to the Reagan Administration have proposed other forms of capitation. I would like to review these.

Capitation reimbursement is an arrangement in which a fixed amount of money is paid per enrollee for a given period of time. The amount paid is independent of the type, frequency, or intensity of services rendered during the contractural period (usually one year). The advantages of capitation to the government are twofold. The first is predictability of cost. Under the current reimbursement methodology, the annual cost of Medicare can only be approximated since the government is billed after the services are given. This makes budgeting difficult. Under capitation the amount of contractural obligation will be known annually prior to rendering of services.

Capitation reimbursement is an arrangement in which a fixed amount of money is paid per enrollee for a given period of time.

Secondly, capitation plans will limit payments to physicians and thus provide cost savings for doctors' services. Additionally the capitation plans will transfer most of the risk for provision of medical care to the contracting parties such as an HMO, PPO, or geographic fiscal intermediary. The proposed capitation strategies involve payment to either a health plan such an HMO, PPO or a geographic fiscal intermediary. Capitation payments to individual physicians are not being considered. Geographic fiscal intermediaries are organizations such as large insurance companies or Blue Cross/Blue Shield groups that would agree to provide medical care services for all Medicare enrollees that reside in a given geographic region such as the state of Florida. The georgraphic fiscal intermediary would be responsible for hiring physicians to provide medical services. Such a program obviously gives the geographic fiscal intermediary the potential for an incredible monopolistic power over medical care within its assigend region. Ambulatory services and physician inpatient services would be covered in any plan. It is uncertain whether any other hospitalization costs, such as those currently covered under Part A of Medicare, would or would not be covered.

Several features of the capitation concept must be recognized. One, the enrollee, or Medicare beneficiary, is the unit of payment. The health care group, such as the HMO or the geographic fiscal intermediary generates additional income by enrolling larger numbers of people. Two, Medicare does not pay the intermediary on the basis of the services used. The intermediary may be able to charge the beneficiary a modest fee such as five dollars for an office visit and perhaps an enrollment fee. In general, any capitation program would interact only with prepaid health care providers. Three, physicians who provide medical services may be paid by one of several means: on a fee-for-service basis, a salary, or by some other contractural arrangement between the HMO and the doctor.

Four, the government's main thrust is to make the intermediary such as the HMO or the geographic fiscal intermediary the bearer of risk for providing medical care services. This is going to be troublesome for some small HMOs and PPOs. The difficulty emerges from statistics. A relatively small number of people (5%) consume 52% of Medicare's total expenditures. Large expenditures, (defined as greater than $20,000 per patient in 1977 dollars) were applied to 0.09% of all beneficiaries. But these people accounted for 2.8% of total program expenditures or 30 times that of the average patient. Financial loss and insolvency threatens smaller intermediaries who randomly enroll more than the predicted number of such high cost individuals. For instance, an HMO with only a thousand enrollees could have its entire operating profit eradicated if three, instead of only one, such high cost individual became enrolled in any given year. Intermediaries can reduce some of these risks by prescreening their enrollees and by excluding high risk patients such as those with history of repeated hospitalizations, chronic cardiac conditions, and chronic musculoskeletal disorders. However, current Medicare capitation contracts specifically forbid such pre-selection of patients. Another means of reducing risk to the intermediary is provided by co-insurance against such catastrophic losses.

Capitation thus transfers the responsibility for medical care from government to some other organization. Will capitation save money for the government? The answer obviously depends upon the capitation fee schedule. Greater use of HMOs reduces medical care costs by reducing the rates of hospitalization; but the costs per hospitalization and all other services are equal to those of fee-for-service providers and the rates of increase in cost are identical to those of fee-for-service physicians. If the government arbitrarily sets fees low, a capitation system will save it money. But the additional costs of medical care that the government does not pay for will have to be transferred to the beneficiary (i.e., the patient) with additional co-payments or by reducing the intensity and frequency of services to such patients. Curtailing services possibly will lead to a decrease in quality. The current political atmosphere in Washington will not permit the transfer of any additional burden to the beneficiary. Policy makers would like to reduce utilization of services without compromising quality but no one knows how to accomplish this goal.

The actual cost savings to government by these capitation proposals will not be as large as government had hoped. A recent study by Health Market Survey has estimated that the current Medicare capitation arrangements now being contracted will save Medicare a cumulative total of only one billion dollars

between 1985 and 1990. This also assumes that HMOs and PPOs that are paid by capitation will enroll a total of 21 million Medicare patients by 1990 — an assumption that is not certainly attainable.

Obviously the contractor who agrees to provide medical services profits from capitation only if medical services are underutilized by the patients or doctors. This threatens quality of care. One study in Washington found that the delay in the diagnosis of colorectal cancer from the time of initial contact to the time of initiation of treatment was 14 days in a fee-for-service practice and 47 days in a prepaid HMO program. Whether such delays in diagnosis will compromise patient health outcomes is unknown.

Capitation thus transfers the responsibility for medical care from government to some other organization.

Access to new technologies might also be inhibited by capitation programs. The history with HMOs has shown that such organizations delay investment in certain types of equipment such as CAT scans. Data do not exist as to whether such delays in access to new technology have any significant long-term impact on patient outcome. Access to specialist care such as joint arthroplasty for arthritically-destroyed joints, or physical therapy, or cataract surgery may also be delayed by a capitation system. Such delays can negatively alter the patient's ability to fulfill his activities of daily living. Unfortunately we lack the experiments that examine these issues. Trials of capitation are in progress but analysis of the data will not be available for at least two more years.

Capitation payment to geographic fiscal intermediaries raises the possibility of other adverse consequences. First, no data exist as to the practicality or to quality of care of such a program. The opportunity for monopoly by an intermediary that was assigned care for an entire state has been mentioned. Such a monopoly could coerce patients into certain selected HMOs or PPOs, and subject physicians to such steep discounts of their fees that the physicians would not participate in the program. This would limit freedom of and access to care.

Apparently physician DRGs, as a method of paying doctors for Medicare services, are languishing because of their impracticality. Capitation is this season's economic rage among health care planners. The proposals under consideration are beclouded by many unanswered questions and the possibility of saving very little income. Hopefully the capitation concept will also wither within the next one to two years.

References

1. Payment for Physicians Services: Strategy for Medicare. Office of Technology Assessment, Washington, D.C. 20510, 1986.
2. Medicare Capitation Means Small Savings, Large Indirect Impact. Health Market Survey, Vol. III, p. 7, April 21, 1986.

Jacques R. Caldwell, M.D.
Daytona Beach

A WORD TO THE WHYS

WHY AMA?

The AMA actively works to represent your interests by fostering legislation that is beneficial both to the medical profession and the public. Each year the AMA makes thousands of contacts with members of congress and their staffs and frequently translates Association policies into model or draft legislation for governmental action. Active representation of organized medicine: it's one more good reason why you should be part of the AMA.

WHY AMA?

Today you can have instant access to a broad range of up-to-the-minute clinical information and protocols for use in patient care through the Medical Information Network. This nationwide, computerized system was developed by the AMA, with General Telephone and Electronics (GTE), to provide you with the most advanced, current scientific information. It's one more reason why you should be a part of the AMA.

WHY AMA?

Residents and medical students now have a strong voice in organized medicine. Through the Resident Physician Section and the Medical Student Section, these two groups participate in the policy making process of the AMA and communicate their concerns. Developing future leadership in organized medicine: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

Thirteenth Annual Review Course for
Certification in Internal Medicine

"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"

August 17-30, 1986
Key Biscayne Hotel and Villas, Key Biscayne
Director: J. Maxwell McKenzie, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for certification in Internal Medicine. It will provide an intensive and comprehensive survey of those aspects of Internal Medicine which should be familiar to internists qualified for certification and recertification. Printed materials with references and self-assessment questionnaires will be provided to all registrants. This course will end ten days prior to the certification examination of the American Board of Internal Medicine.

A faculty especially selected for its expertise in review courses will present the following topics:

Week I	Week II
Cardiology	Infectious Diseases-Immunololgy
Pulmonary	Nuclear Medicine-Oncology-Genetics
Toxicology-Hypertension-Hepatology	Endocrinology
Renal-Acid Base	Gastroenterology
Rheumatology	Ophthalmology-Critical Care-Dermatology Laboratory
Hematology	Radiology-Neurology-Psychiatry

Highlights

State of the Art Lectures	88 credit hours in Category I
Patient Managment Problems	Self-Assessment Questionnaire Sessions
Pictorial Quizzes	Videotape Symposiums
Syllabuses	Audio-Visual Aids
Meet the Faculty Sessions	

Registration: Entire Course (August 17-30) $750 (before 5/31)
$800 (after 5/31)
Week I (August 17-23) $550
Week II (August 25-30) $550

Includes tuition, printed materials, use of audiovisual aids, library loan of T.V., tapes, cassette tapes and set of slides.

For registration and information write to:
J. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101 Telephone: (305)547-6063



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.
Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

THE MEDICAL SYSTEM INCLUDES:
- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

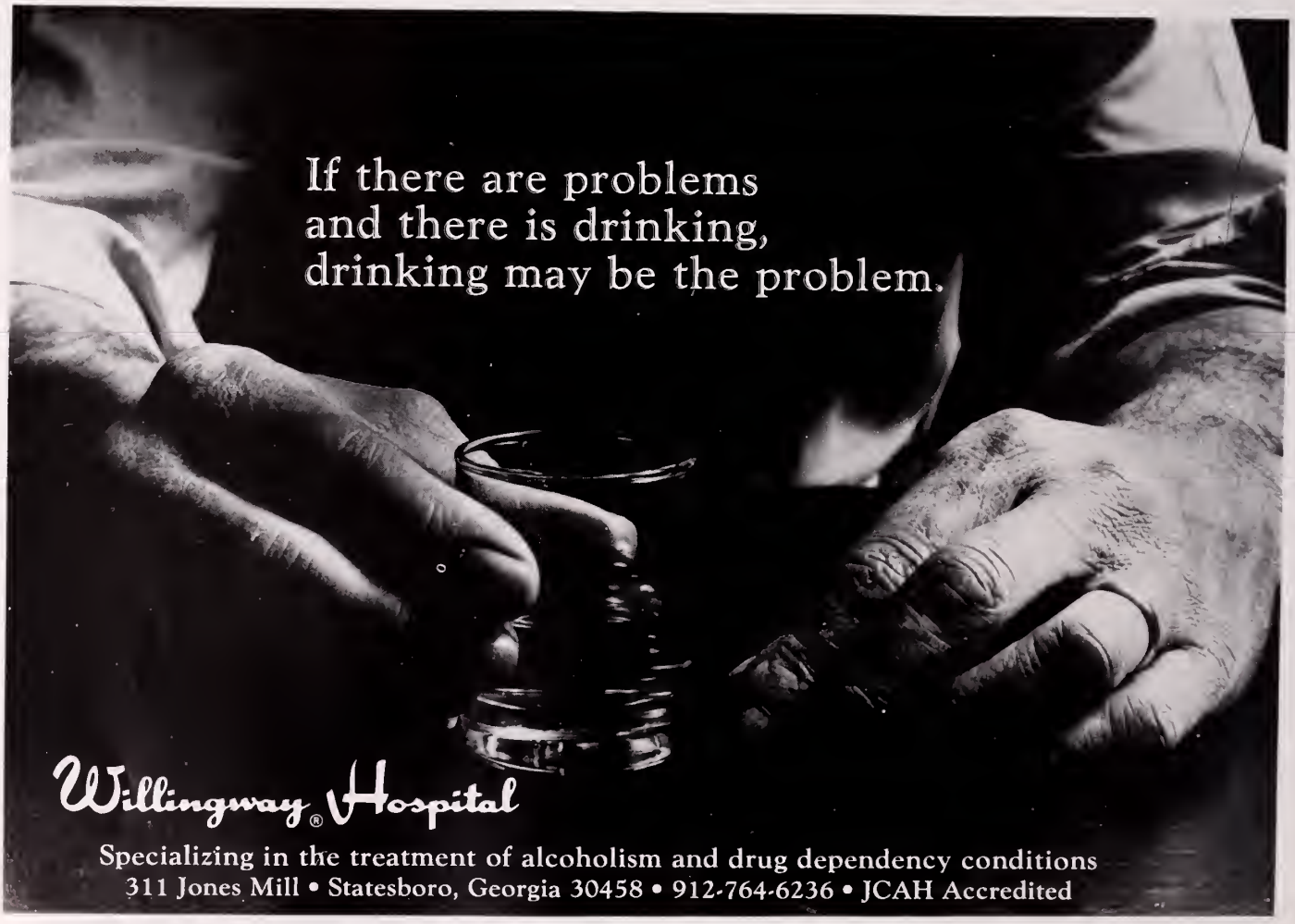
ADVANTAGES
- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

INTERESTED?
For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

The ISI Software Question

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.

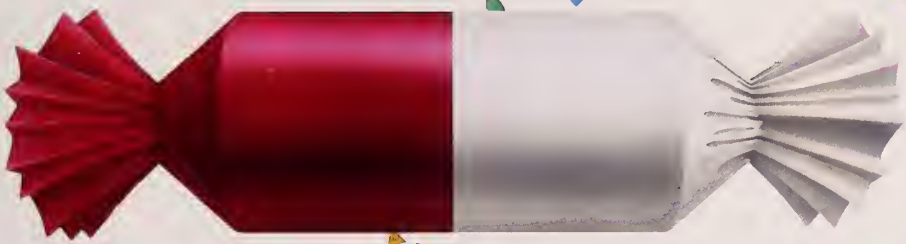


Willingway® Hospital

Specializing in the treatment of alcoholism and drug dependency conditions
311 Jones Mill • Statesboro, Georgia 30458 • 912-764-6236 • JCAH Accredited

10 YEARS

Thank you for your loyal support



DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

SK&F CO.


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

knoll® **KNOLL PHARMACEUTICAL COMPANY**
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2406

EMPLOYEES APPRECIATE THE PAYROLL SAVINGS PLAN.

JUST ASK THE PEOPLE AT THE BOEING COMPANY.

"My folks gave me a Bond for my birthday every year. Now I can do the same for my kids."
—Vaughn Hale



"It's certainly a painless way to save. The money comes directly out of my paycheck every two weeks."
—Florence Perry



"This is one way I can support my government and save at the same time."
—Douglas Scribner



U.S. Savings Bonds now offer higher variable interest rates *and* a guaranteed return. Your employees will appreciate that. They'll also appreciate your giving them the easiest, surest way to save.

For more information, write to: Steven R. Mead, Executive Director, U.S. Savings Bonds Division, Department of the Treasury, Washington, DC 20226.



U.S. SAVINGS BONDS
Paying Better Than Ever

A public service of this publication.

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 407
- ☐ DEAN'S MESSAGE, 408
- ☐ ENCORES!, 409

☐ NOTES & NEWS

Costs up, access threatened OB/GYN study shows

Professional liability continues to drive OB/GYN costs higher in the United States and threatens to limit access to quality care according to a 1985 survey released by The American College of Obstetricians and Gynecologists (ACOG).

The survey of 1,400 OB/GYNS conducted in June and July looked at what effects the threat of malpractice suits had on the practice of obstetrics and gynecology.

William Mixson, M.D., president of ACOG, said "The trends we measured in 1983 are continuing to plague this specialty and the women it serves." More than nine out of 10 OB/GYNS reported an increase in insurance premiums during the past two years. This compares with 62% reporting raises two years ago. The average increase is $9,871 with almost one out of four OB/GYNS seeing insurance premiums increase by $13,000 or more. The highest increases were in New York ($21,635) and Florida ($17,131). It now costs OB/GYNS about 10% of their gross income simply to get basic insurance coverage. In New York State it is 16%.

"As we saw in 1983, not all physicians passed on the increases to their patients," Mixson pointed out, "but in the last two years, more than eight out 10 did increase their fees because of the larger insurance premiums. Whereas, in 1983 fewer than one half increased their fees more than 10% to meet this cost, today six out of 10 did so."

Dr. Mixson said that the average premiums are more than $20,800. The percentage of doctors who pay $25,000 or more has nearly tripled in two years from 9.4% to 27% this year. Almost one out of every eight physicians pays $35,000 or more in malpractice insurance premiums today. Some 14% pay premiums of less than $8,000; in 1983, 30% paid such premiums.

Along with this direct increase in insurance premium costs is the continuing use of defensive medicine. For example, two thirds of all OB/GYNS report that they have increased the use of diagnostic tests and spend more time documenting their activities in response to the threat of claims.

Dr. Mixson said that some of the added testing is good medical practice and some is undoubtedly used simply to protect the physician in case of a suit. "In either case," he said, "it's the patient who pays."

The other major area where patient services suffer and will continue to suffer according to Mixson, "is the availability of quality care. Family physicians in some communities can no longer afford to carry professional liability insurance to cover obstetrics, and nurse midwives have lost insurance coverage in much of the country. The data show that the number of physicians giving up obstetrics and cutting down on high risk obstetrics is rising."

In 1983, 9% reported they had dropped obstetrics because of the threat of suits; today, that has risen to 12%. Today, 14% reported that they had decreased the number of deliveries they handle compared to 10% two years ago.

"The most dramatic and discouraging trend," Mixson said, "is the growing proportion of physicians who are decreasing the level of high risk obstetrics. It is here where we need the most skillful and dedicated physicians. Yet it is here that we see a growing number shying away. This year, 23% reported that they have decreased the level of high risk obstetrics compared to 18% two years ago. Among those who have been sued three times or more, 30% have decreased the level of high risk obstetrics. Of those who stopped practicing obstetrics," Mixson said, "more than half gave it up between the ages of 35 and 54, and 25% gave it up before the age of 45.

"Other data from the American Board of Obstetrics and Gynecology show that young physicians seem to be shunning the specialty of perinatology-obstetricians who care specially for high risk pregnancies. Of the 75 programs in the field, 45 show vacancies today."

In the present study, almost three quarters of the physicians reported that they had claims filed against them. This compared with two thirds in 1983. Of those that went to trial, the physician won or the case was dropped in more than eight out 10 cases — this is consistent with other reports.

Dr. Mixson pointed to "another failure in the system — the amount of time it takes to bring and settle a claim. A patient truly injured in the system deserves prompt payment of compensation. The survey shows that the time elapsed between when the incident took place and the time the claim was filed was more than a year in 43% of the cases, and more than three years in 9%. Add to that the 46% of the cases where settlement took more than two additional

years, "and we begin to see how long it takes many cases to be determined." Mixson said, "In contested cases, 55% took longer than two years, and 11% more than five from claim to final resolution. In New York and California, 85% took more than two years and in New York, 23% more than five years. This system serves neither the patient nor the doctor very well."

This 1985 survey was conducted for ACOG by Needham, Proter, and Novelli, Inc., a Washington, D.C., based survey company.

University of Florida announces expanded hospital board of directors

University of Florida President Marshall Criser has announced the appointment of five additional members to the board of directors of University Medical Center Inc. in accordance with an agreement signed by both institutions in November 1985. University Medical Center Inc. is a private, not-for-profit corporation which operates University Hospital of Jacksonville.

Criser announced the appointments of John Ives, Wilford Lyon Jr., W.A. McGriff III, Gerold Schiebler, M.D., and H. Jay Skelton.

Ives is the executive vice president of Shands Hospital in Gainesville. A graduate of Dartmouth College and Yale University, Ives is a member of the board of directors of Flagship Bank of Gainesville, a member of the board of trustees and chairman of the Florida Hospital Association, a member of the Society of Health Service Administrators and the American Hospital Association, and is the president of the Consortium for the Study of University Teaching Hospitals.

Lyon is chairman of the board and chief executive officer of Independent Insurance Group, in Jacksonville. The Independent Life and Accident Insurance Company is a wholly owned subsidiary of the Independent Insurance Group Inc. Lyon graduated from Georgia Institute of Technology and Georgia State College. He is a member of the board of directors of Florida National Banks of Florida Inc., the United Way Executive Committee, the board of directors of the Gator Bowl Association, and is the Florida state vice president of the American Council of Life Insurance, Washington, D.C.

McGriff is the president of Alliance Mortgage Company in Jacksonville. A graduate of the University of Florida, McGriff is a member of the board of directors of Florida National Bank and Florida National Banks of Florida Inc., past president of the Mortgage Bankers Association of Florida, and a trustee of the Mortgage Bankers of Florida Political Action Committee.

Dr. Schiebler is the associate vice president for health affairs for external relations for the University of Florida Health Science Center. A graduate of Franklin and Marshall College, Schiebler earned his M.D. from Harvard Medical School and was a post-doctoral research fellow at the University of Minnesota Hospitals and the Mayo Clinic and Foundation. He is legislative liaison for the Unversity of Florida Health Science Center and sits on the editorial board of *Clinical Pediatrics*.

Skelton is managing partner of the Jacksonville office of Peat Marwick. He graduated from Central Missouri State University and holds CPA certificates from the states of Florida and Missouri. Skelton is a member of the Florida Institute of Certified Public Accountants, the American Institute of Certified Public Accountants, the board of governors of the Jacksonville area Chamber of Commerce, and the steering committee to the School of Accounting at the University of Florida.

The new appointees join current board members Roy Baker, M.D., W.E. Addy, Roger Baker, M.D., William Deal, M.D., Jack Demetree, Charles McIntosh, M.D., Gene McLeod, Harold O'Steen, George Register Jr., Ronald Rhatigan, M.D., and John F. Gregg.

Officials of the University of Florida and University Hospital signed an agreement November 1985, making the hospital a major affiliate of the University of Florida Health Science Center. Included within the scope of the document was the agreement to appoint five additional members to the University Medical Center Inc. board of directors to be named by the president of the University of Florida.

The University of Florida Health Science Center at Gainesville encompasses six colleges involved in the education of health professionals and three affiliated hospitals serving the referral needs of Florida and the southeast. The center includes an extensive network of urban and rural clinics and provides community and professional educational programs statewide.

University Hospital of Jacksonville became one of the country's first public hospitals in 1870. It began formal medical education in 1925. In 1982, the hospital became a private, not-for-profit health care facility operated by University Medical Center Inc.

DEAN'S MESSAGE

New curriculum proposal for the University of Florida

More than two years ago the Curriculum Committee at the University of Florida undertook the task of reviewing the curriculum to make recommenda-

tions for the future. Each member of the Curriculum Committee was charged with chairing at least two subcommittees consisting of basic scientists, clinical scientists, and students. These subcommittees reviewed each course as the students went through them. Committee members attended lectures, laboratories, ward rounds, and even occasionally followed the students while on night call. Each committee chairman then submitted a written report to the Curriculum Committee. In July 1985, a retreat was held and an initial proposal was developed which, among other things, suggested that the final two years of medical school be a single unit and that junior and senior students intermingle on the wards. This idea was not acceptable to either the faculty or students at the University of Florida, and therefore a revised proposal has been offered to the faculty.

In this new proposal the basic science portion received considerable alteration. First, the time for the basic sciences would be extended from fifteen months to the more traditional eighteen months without adding teaching hours. Contact hours, including laboratories, would be reduced from an average of thirty to an average of twenty-five per week. The object would be to de-intensify what is perceived to be a very rigorous basic science schedule that is currently compressed into a less than adequate time frame. Thus, students should be better able to appreciate and enjoy their experiences during these initial years of medical school.

Additions to the first year include a series of seminars in which small groups of students would meet with a pair of faculty members throughout both semesters. The pair of faculty members would consist of one basic scientist and one clinical scientist, and they would lead discussions concerning interpretation and appreciation of scientific literature as well as other areas of more general medical interest that the individual groups identify as they progress through the year. Also added to the first year would be a series of clinical correlation seminars. To help make these seminars practical and real, a Clinical Resource Committee would be available to help plan and implement these sessions. This resource committee, made up of basic scientists and clinical scientists, would also suggest and devise ways in which basic scientists could actively participate in the clinical portions of the curriculum. Another addition to the second year would be a course addressing epidemiology, public health and biostatistics and would be jointly coordinated by members of the Departments of Medicine, Community Health and Family Medicine, and Pediatrics.

The third year, the clinical clerkship year, was left largely intact. However, the students would be allowed to displace one of the traditional clerkships into the fourth year and take eight weeks of elective in its place. This manipulation was designed to provide some flexibility and choice during this currently very structured year. The fourth year remains essentially unchanged and consists of four weeks of required Medicine, Surgery, and Clinical Pharmacology and Therapeutics, the last representing a blend of clinical and basic science pharmacology. The remainder of the year would consist of elective choices.

An additional alternative offered for the first time would be a specifically designed three-year track for the basic science years. Students choosing this track would be allowed to spread out the basic science courses over a three-year period rather than the traditional two-year period. In this way, they would be able to initiate or complete research projects or perhaps become involved in such activities as public health, hospital administration, or even courses that would further their development in the arts and humanities. Also, some students may feel the need for more time to master the basic science aspects of medicine. These students might be those who have entered medical school without the traditionally heavy emphasis on basic sciences in their premedical years.

At this moment, the Curriculum Committee and the Dean are awaiting the vote of the faculty on the proposal. The entire two-year plus examination process has utilized 107 faculty members, students, and consultants. As a result, a considerable amount of attention has been focused on medical education and teaching in this school. It is gratifying to know just how much concern our faculty members have when it comes to designing a course of study for our future physicians. On the day that the proposal was presented to the faculty, the auditorium was filled to the point where many faculty members had to sit in the aisles. Needless to say a lively and academic discussion ensued — the kind of thing that should go on in medical schools.

Charles P. Gibbs, M.D.
Assistant Dean for Curriculum
William B. Deal, M.D.
Dean and Associate Vice President for Clinical Affairs
University of Florida
College of Medicine

ENCORES!

Capitation helping win war against high cost of health care

The soaring health costs of the 1970's have triggered off a reimbursement revolution that is changing the face of modern medicine.

Under the old way, the doctor or hospital submitted an itemized bill for their services. This was

an open invitation to overprescribe and overspend. The result was a medical price spiral that every year outpaced inflation by up to three times.

From 1965 to the present, the share of the gross national product for health care leaped from 6% to nearly 11%.

The reimbursement revolution has put the brakes to this and made our health care system far more cost-effective than ever before. Best of all, the quality of care has not suffered through all this.

This new payment system is based on the capitation principle: paying a predetermined amount for a cluster of medical services to the patient. That puts an end to the old blank-check mentality.

Capitation puts the provider at economic risk. Overprovided services are not rewarded; they are penalized because price has been determined in advance. That is the way the rest of the free-market system works, and it has performed economic wonders by keeping prices down and quality up.

Economic pressures • Capitation is already in place today — and working. Medicare's prospective payment system has drastically slowed annual hospital inflation, while reducing average patient stay by an unprecedented two days.

The capitation idea is at work elsewhere, too. When a health maintenance organization, for example, agrees to provide comprehensive care to its members for a prepaid monthly sum, it is using the capitation concept. The HMO is under the same economic pressure either to be efficient or lose money.

Under this pressure, HMOs provide cost-effective care. For one thing, they hospitalize their members far less than health plans that reimburse retrospectively. They also have an incentive to keep people healthy.

Last April, Medicare launched a program to encourage Medicare beneficiaries to join an HMO. For each beneficiary enrolled, the Government pays the HMO 95% of what it costs a conventional plan in the area to provide the same care. If the HMO can deliver this care for less, it must provide the Medicare beneficiary with a rebate or additional services that Medicare does not cover, such as eyeglasses.

The half-million Medicare beneficiaries that belong to one of the 118 HMOs that now operate this way are getting an average of $32 a month in benefits they would not otherwise have received. Prepaid plans are lining up to sign risk contracts because it gives them access to the 30-million strong Medicare market.

Geographic capitation • By autumn of next year, we project that 2.5 million Medicare beneficiaries will be enrolled in HMOs. Meanwhile, the HMO concept is picking up momentum outside the Medicare program; some observers predict that 50 million Americans will belong to prepaid plans by the early 1990's.

There are still other possibilities to explore with capitation. One approach, for example, is to apply it to a whole state or geographic area. In such a program, Uncle Sam would negotiate with an insuring group to cover every Medicare beneficiary in a given area. For one overall price, the insurer agrees to provide the Medicare package to every beneficiary in that area. If they can deliver this care for less, they earn a profit. Otherwise, they go in the red. This puts the whole medical marketplace in that area on a highly competitive footing. There are solid advantages to this:

- It would keep our pluralistic health care system intact.

- It would give Uncle Sam control over aggregate Medicare outlays in this era of Gramm-Rudman budget restrictions.

- It would turn over management responsibility to the private sector, thus keeping Government red tape to a minimum.

- It would help safeguard quality care, since the doctor's traditional role as the patient's advocate would remain in place.

- And it might even ensure that doctors can hang on to the fee-for-service payment system, because the individual payment mechanism used would not really matter under an aggregate-limit system.

Right now, geographic capitation is a gleam in the Government's eye. It needs more study and field testing, which will take a few years.

The war on high costs is not won yet, but we are getting there and capitation is leading the way. It is an idea whose time has come and a payment concept that lets doctors be doctors. Physicians should welcome that.

Otis R. Bowen, M.D.
Secretary
Health and Human Services

Reprinted with permission from *Physicians Financial News*, May 15, 1986, pg. 2.

Imagine a doctor having to take a salary cut to get a job

It could happen, and sooner than you think

For decades, the typical American doctor was in "solo practice" — self-employed, practicing alone in a private office, charging a fee for each service, operating as a small business and making a substantial living.

But that situation is about to change.

In the next 15 to 20 years, doctors can expect these developments, according to doctors, health economists and other experts assembled at a Cornell University Medical College conference in New York earlier this year:

- The proportion of doctors in solo practice using the fee-for-service payment method will plummet, perhaps becoming insignificant.

Just how much solo practice will decline is in dispute. Some authorities, like Gerard Anderson of the Johns Hopkins School of Public Health, say that as few as 25% of doctors will be solo practitioners by 2000. Others believe the percent will be lower.

- Half or more of the nation's doctors will be working for a salary or under a fee-discounting agreement with health maintenance organizations (HMOs) and other groups.

This will occur because more and more patients will be treated under arrangements like HMOs in which they receive whatever treatment they need for a flat, annual fee. These arrangements require the HMO to keep doctor costs fixed and predictable.

While the number of doctors working substantially full-time for HMOs is quite small today — estimates range from 7,000 to 18,000 — it will increase enormously as HMOs capture a larger share of the market.

HMOs have 18.9 million members now, compared with fewer than 3 million 13 years ago. While this still represents only a small fraction of the U.S. population, some analysts predict HMOs will capture half the nation's patient population within another decade or so.

- New types of "vertically integrated" health care systems will emerge as providers attempt to keep costs low. These large health care corporations — some nonprofit and some for-profit — simultaneously sell health insurance and operate HMOs, hospitals, nursing homes, medical labs and medical supply companies.

Today there are just a handful of these companies. But their numbers are also expected to grow enormously.

- A large portion of the doctors who are not working for HMOs or health care corporations will combine into group practices to share expenses and to offer a wide range of "one-stop-shopping" services, making use of medical techniques and expensive machinery previously found mainly in hospitals.

As a result of all these changes, some authorities predict that by the end of the century, 50% or more of the nation's physicians will be working for a salary.

"We believe that by 1995, the majority of physicians will be organized into collective bargaining units and will be paid on a salaried basis," wrote Richard Averill, a vice president of Health Systems International, and Michael J. Kallison, a health law specialist, in a recent issue of *Review*, the magazine of the Federation of American Health Systems.

Others, like James D. Bentley, an official of the Association of American Medical Colleges, say perhaps only a third of the doctors will be salaried. But even that would amount to a huge increase.

- Physicians' incomes will drop. "Physicians' incomes have gone down 1% a year in real (after-inflation) terms" for several years, says Robert J. Rubin, who is in charge of policy analysis at ICF Inc., a research firm.

"That trend will continue and perhaps accelerate," he says. "They will still do well, but the days of astronomical incomes are going to change, particularly at the upper limit for some surgical specialties."

Fifteen years from now, the average doctor who takes care of patients will net $90,000 a year after expenses, but before taxes, based on 1984 dollars, Anderson says. That compares with $108,400 today. Bentley says some analysts believe the drop will be greater — to between $60,000 and $75,000.

While this is substantially less than now, Bentley says, it is still far more than the $26,433 median family income for the nation as a whole. "We will not have any physicians driving cabs," says Bentley. "I do not foresee that."

Of course, these numbers are "soft" and conjectural. But while there are disagreements about specific numbers, there is relatively widespread agreement on the overall trends, because of three major developments that are beginning to change the medical landscape.

One is the enormous pressure, generated over the last decade by government, business and patients, to hold down medical costs. The second is a growing surplus of doctors, caused by large medical school enrollments over the past generation (now starting to decline), plus the admission of foreign graduates.

Third, there is a surplus of hospital beds nationally.

Some experts, like Paul Ellwood, founder of Interstudy, a Minneapolis medical think tank, and now head of his own health economics firm, predict that this cost-cutting pressure will result in a substantial consolidation of health services and organizations over the next decades.

Huge organizations will emerge to handle virtually every aspect of health care. They will run health plans, hire their own doctors, market insurance and create HMOs. They may buy and operate hospitals.

Providing a full range of services, they can capture patients with simple, one-stop-shopping appeals; they can channel their HMO patients into their own hospitals, making sure they do not have too many rooms empty; they can make deals with other hospitals to get low rates when they send them pa-

tients; they can hire young doctors at lower salaries because of the surplus.

Already, such consolidation has begun. CIGNA Corp. (formerly Connecticut General Life Insurance), a leading health insurance company, already owns 18 HMOs, some dental HMOs and a share of one hospital. CIGNA continues to sell health insurance and has arrangements with groups of doctors and hospitals to provide low-cost services, according to executive vice president Robert Patricelli.

Hospital Corp. of America and Humana are moving in the same direction, and nonprofit hospitals and HMOs are expected to do the same. In some cases, a hospital will expand and start selling health insurance and running an HMO and its own hospital supply company. In others, an HMO will start creating a "vertical" business of this type, or a private doctor group.

By some time in the 1990s, anywhere from eight to 20 large vertically-integrated organizations will provide the bulk of medical care in the United States, Ellwood predicts.

Some say this prediction is too extreme. Anderson, for example, says there will be some consolidation, but "it is not clear that such vertically integrated health systems can produce health care at substantially lower costs than free-standing hospitals and private doctors."

The fee-for-service system, in which the doctor sets the fee, and similar open-ended systems for hospitals and nursing homes, have been blamed by many for the rise of health costs.

The favored solution has been a move toward flat-rate payment systems, like those used by HMOs in which the hospital is given a single payment regardless of how many days the patient stays or how many tests are conducted. With a fixed premium, the HMO must operate efficiently or lose money.

Studies have shown that well-managed HMOs, such as the Kaiser-Permanente program, usually have fewer hospital days and lower doctor costs per patient than if the patient's care was supplied by doctors who charged a fee every time a service was provided.

The past scarcity of doctors will soon turn to a surplus, according to the federal Graduate Medical Education National Advisory Committee (GMENAC) and HHS's Bureau of Health Professions.

The bureau projects that the number of physicians, now about 500,000 or double what it was in 1960, will rise to 594,600 in 1990 and 706,500 by 2000. This would create an oversupply of about 35,000 in 1990 and 52,000 in 2000. The GMENAC study, using somewhat different assumptions and bases, put the oversupply at 137,200 in 2000.

The expected result is that young doctors will find it more difficult to get started in private practice and will turn increasingly to salaried jobs. They will also work for less than in the past.

Another reason why solo practice will become less attractive is the large college tuition loans many doctors must repay after medical school. A new medical school graduate can easily face a debt of $50,000. Then, says Donald Fisher, executive vice president of the American Group Practice Association, it can cost an added $80,000 to start an office, and take several years before a profitable practice is built.

Many young doctors prefer to join HMOs or an established physician's practice and start earning a salary immediately. Others go into private practice, but agree to provide services to patients referred by the organization at a discount from their normal office fee. The hope is to win more patients by offering a discount.

In one version of this arrangement, a so-called preferred provider organization agrees with, say, a company to have one of the organization's doctors treat the firm's employees at a certain price. The doctor can continue to treat his own regular patients for his usual fee. Another version, the independent practice association, is similar, but the purchaser of services is typically an HMO.

Although the doctor surplus has not yet hit, there are signs it is beginning. In some areas with many medical schools and many graduates, some doctors are starting work with HMOs after three years of internal medicine residency and completion of board certification exams for salaries as low as $35,000.

Marc Bard, M.D., chief of doctor recruitment at Harvard Community Health Plan, says $50,000 was about the going rate for a good starting internist after three years of residency in many cities. But he says the downward pressure on pay will start in a few years.

Spencer Rich
Washington, D.C.

Reprinted with permission from *The Washington Post National Weekly Edition*, May 5, 1986.

It is still a privilege to be a doctor

I have been dean for student affairs at Harvard Medical School for eight years. It is my responsibility and privilege to listen to medical students and to support their personal and professional development. What they have been telling me this year troubles me. It is exemplified by a recent encounter with a third-year student.

The student was distressed. What had sustained him through the preclinical years was the anticipation of learning patient care. Now he had earned the right to wear a white coat and enter the wards. What he had encountered had discouraged him profoundly. The problem was not the work; that was as exciting as he had hoped it would be. It was his interaction

with his teachers. Once the formal teaching rounds were over, they talked only about the problems they faced. For some, the talk was about the malpractice crisis, the freeze on Medicare fees, the impact of diagnosis-related groups, and shrinking incomes. For others, it was the endless paper work in applying for research funding, the competition for the declining number of grants, and the uncertainties of sustaining a research career. Medicine, they said, was no fun any more. If students were included in the conversations, the faculty reminisced about the good old days, which neither they nor the students would ever see. They wondered aloud whether they would choose medicine if they had it to do all over again.

I have heard perhaps a dozen similar stories from students doing clerkships at some of Boston's leading teaching hospitals. But the lamentations about the woes afflicting medicine are hardly limited to teaching faculty. Almost every week, and sometimes daily, one or the other of the media quotes practitioners who threaten to close their offices if they are not granted relief from what they consider onerous restrictions on their income or their right to practice freely. All this hits students hard because they are already worried about the indebtedness they are incurring, particularly in view of the stories about the doctor glut, declining incomes, and the increasing competition for residency positions. They fear that their debts will force them to choose specialties on the basis of anticipated earnings rather than intrinsic interest. Indeed, some, in the role of tutors for premedical students, have begun to dissuade the college students they advise from choosing medicine, because they consider the prospects to be so bleak.

How absurd! It stands the world on its head to suggest that the liabilities of a career in medicine outweigh the assets. Of course there are major problems in the delivery of medical care, and we ought to be in the vanguard of those seeking solutions to them. But to lose sight of just how lucky we are to have a profession in which we do well for ourselves by doing well for others reflects a puzzling loss of perspective. The satisfaction of being able to relieve pain and restore function, the intellecutal challenge of solving clinical problems, and the variety of human issues we confront in daily clinical practice will remain the essence of doctoring, whatever the changes in the organizational and economic structure of medicine.

Although physicians' incomes may have declined in real dollars in the 1980s, they remain in the upper decile of all U.S. incomes. Although the practice of medicine may be increasingly vexed by bureaucratic constraints, doctors still retain a degree of autonomy in their clinical activities that is rarely found in other occupations. Although research support may not have kept up with inflation, the opportunities for young investigators in this country exceed those to be found anywhere else in the world and are several orders of magnitude greater than they were 40 years ago.

Let us put first things first. Medicine is still a great profession, one held in high esteem by the majority of the public, despite the increase in malpractice suits. Our students look to us as role models for their careers. What we must make sure they learn from us are the personal gratifications medicine brings and the obligation to public service it entails. Of course there are reasons for concern when cost controls are emphasized to the detriment of clinical care, when the untoward outcomes inevitable even with the best medical practice lead to charges of malpractice, and when false economies jeopardize the very research that can improve those outcomes.

But if we are to reverse these trends, we must mobilize our natural allies — our patients and the public at large. It is they who have the greatest stake in the battle to preserve excellence in medical care. Cutbacks in Medicaid and Medicare threaten the health of the poor and the elderly — far more than they do physician incomes. Given the promise of basic research, which has paid off so handsomely in better medicine, cutbacks in federal support penalize the ill whose suffering would have been prevented by the new knowledge — far more than they do research careers. If we focus on our primary responsibility to serve as advocates for our patients, we will both maintain our professional integrity and provide the leadership for a broad public coalition in defense of health care. As long as we emphasize self-serving complaints — threats to our incomes and to our freedom to practice as we see fit — we will remain isolated and impotent.

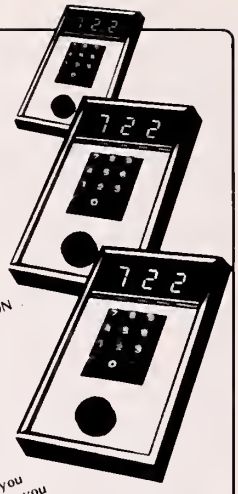
As physicians, we have a moral imperative to sustain the highest aspirations of the students we teach. In taking this position, I do not mean to be a Pollyanna. Our students need to know about the problems facing medicine. But those problems need to be seen in perspective. Medical education does not exist to provide doctors with an opportunity to earn a living, but to improve the health of the public. Let us enlist our students in the campaign for equity and quality in medical care. If that campaign is to succeed, it will need the efforts of the best and the brightest.

What we do as doctors, most of the time, is deeply gratifying, whatever the mix of patient care, research, and teaching in our individual careers. I cannot imagine a more satisfying calling. Let us make sure our students hear that message from us.

Carola Eisenberg, M.D.
Boston, Massachusetts

Reprinted with permission from *The New England Journal of Medicine*, Vol. 314, No. 17, April 24, 1986.

The Message Is Silent ... The Message Is Everywhere!



THAT IS DIGIT-UP® SILENT DIGITAL COMMUNICATION
SILENT AND EVERYWHERE!

Doctors in large solo practices and group practices are reporting Digit-Up's® 3 digit codes to be adaptable to their individual needs and virtually unlimited in communicating simple as well as complex silent messages to large numbers of personnel throughout their offices.

If your staff consists of 5 or more members and you have a need to communicate to 5 to 200 locations, you owe it to your practice to learn more about the amazing Digit-Up® System.

digit up® TRADE MARK

Interested? Please write for a free brochure or call:
FL 1-904-726-4303
USA 1-800-344-4887

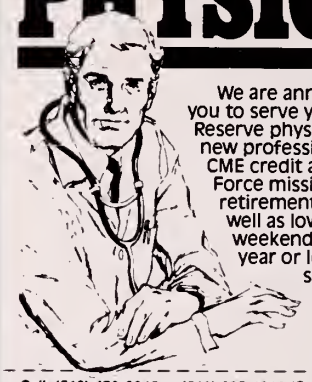
Please send me more information on the DIGIT-UP® communication system.

Name _____ Zip _____
Address _____
Phone _____ Locations: # _____
Satff Members: # _____

RETURN TO: DIGIT-UP® CORPORATION
Post Office Box 957
Floral City, FL 32636

OR CALL: FL 1-904-726-4303
USA 1-800-Digit Up

PHYSICIANS



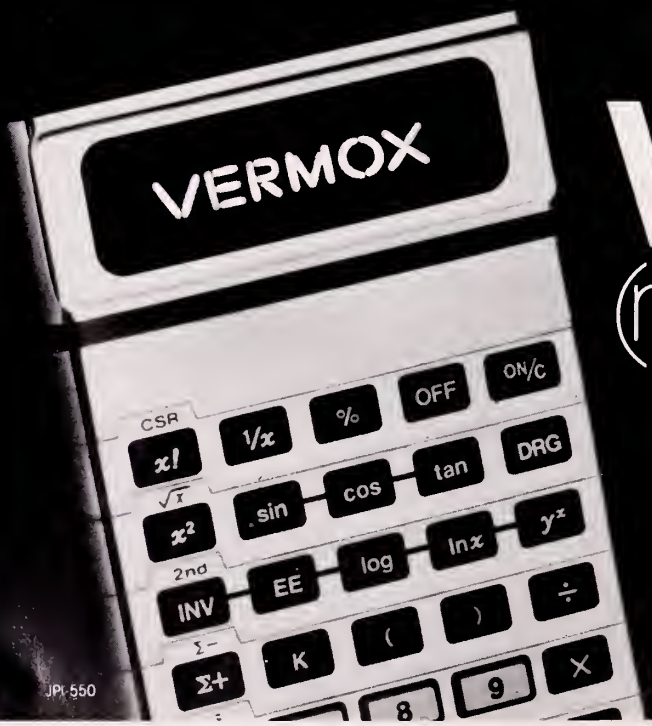
We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HQ 10 AF/RSH
Bergstrom AFB, TX 78743-8002
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Prior Service? Yes ___ No ___
Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE

No need for dosage calculations...



VERMOX®
(mebendazole)

CHEWABLE TABLETS

JANSSEN PHARMACEUTICA
Piscataway, NJ 08854-3998

© Janssen Pharmaceutica Inc 1985

Motrin® 800 TABLETS mg

ibuprofen



Extra strength
Convenience
Economy

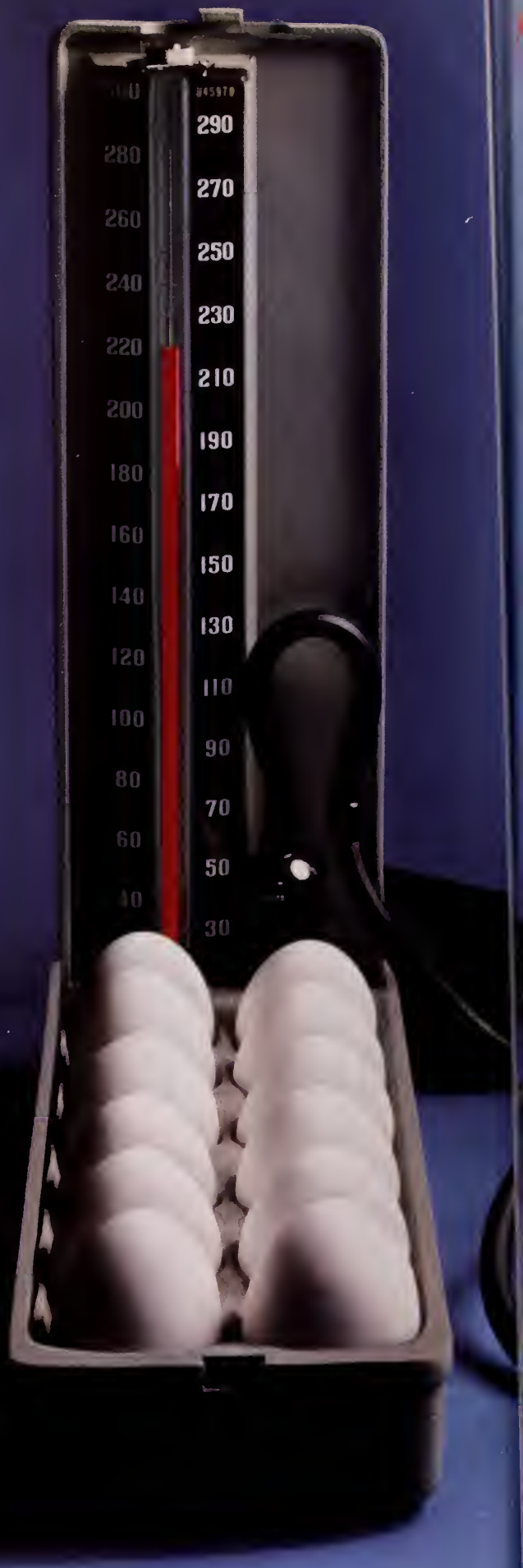
Upjohn

A Century of Caring
1886·1986

© 1986 The Upjohn Company

J-6138 January 1986

"High blood pressure should be a red flag to screen for cholesterol..."[1]



Wyeth Laboratories
Philadelphia, PA 19101

If your patients have hypertension, they probably have high cholesterol too.

The Framingham Heart Study[2] showed that over two thirds of the 35 and older population in that study with systolic blood pressures over 145 mmHg also had serum cholesterol levels of 225 mg/dL or more, and 46% had levels above 250 mg/dL.

While many clinical laboratories still report 250 mg/dL as "normal" cholesterol, the NIH Consensus Development Conference Statement on Cholesterol and Heart Disease[3] stated that any level above 220 mg/dL is associated with a significantly increased risk of coronary heart disease.

You need to know, because high cholesterol parallels high blood pressure as a CHD risk factor.

Epidemiological studies and large-scale prevention trials have indicated that as with blood pressure, serum cholesterol levels are proportionately related to CHD risk.

Specifically, *"...for every 10 mmHg rise in pressure, there appears to be about a 30% rise in cardiovascular risk."*[4] *"...for every one percent you go up the American cholesterol scale, your subsequent rate of heart attack rises two to three percent."*[5]

And although the specific impact on CHD has not been determined, we know that many of the principal agents used to lower blood pressure actually increase cholesterol.

Wytensin® lowers blood pressure effectively without raising cholesterol.

While Wytensin is not a cholesterol-lowering agent and is not indicated for the treatment of hyperlipidemia, in controlled clinical trials[6] it caused a slight, sustained decrease in total cholesterol without reducing the HDL fraction or altering serum triglycerides.

At the same time, Wytensin lowered blood pressure as effectively as hydrochlorothiazide, propranolol, clonidine or methyldopa. Drowsiness and/or dry mouth, the most frequent side effects noted with Wytensin, usually diminish or disappear over time. In fact, in double-blind studies to date, discontinuance of therapy for all side effects occurred in about 13% of patients.

Wytensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol



See important information on following page.

References: 1. Glueck CJ: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 2. *The Framingham Study, An epidemiological investigation of cardiovascular disease*, Section 28, U.S. Dept. of Health, Education, and Welfare. 3. National Institutes of Health Consensus Development Conference Statement, 1984: Vol 5, No 7, p 4. 4. Chobanian AV: The influence of hypertension and other hemodynamic factors in atherogenesis. *Progress in Cardiovascular Diseases, XXVI* (3): 177, Nov/Dec, 1983. 5. Castelli WP: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 6. Data on file, Wyeth Laboratories.

© 1985, Wyeth Laboratories

Wytensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

Brief Summary

Before prescribing, consult the complete package circular.

Indications and Usage: Treatment of hypertension, alone or in combination with a thiazide diuretic.

Contraindication: Known sensitivity to the drug.

Precautions: 1. Sedation: Causes sedation or drowsiness in a large fraction of patients. When used with centrally active depressants, e.g., phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects. 2. Patients with vascular insufficiency: Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure. 3. Rebound: Sudden cessation of therapy with central alpha agonists like **Wytensin** may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology.

INFORMATION FOR PATIENTS: Advise patients on **Wytensin** to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy. Warn patients that tolerance for alcohol and other CNS depressants may be diminished. Advise patients not to discontinue therapy abruptly.

LAB TESTS: In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy. Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test. During long-term use there was small decrease in serum cholesterol and total triglycerides without change in high-density lipoprotein fraction. In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease.

DRUG INTERACTIONS: **Wytensin** was not demonstrated to cause drug interactions when given with other drugs, e.g., digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antiinfective agents, in clinical trials. However, potential for increased sedation when given concomitantly with CNS depressants should be noted.

DRUG/LAB TEST INTERACTIONS: No lab test abnormalities were identified with **Wytensin** use.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: No evidence of carcinogenic potential emerged in rats during a two-year oral study with **Wytensin** at up to 9.5 mg/kg/day, i.e., about 10 times maximum recommended human dose. In the Salmonella microsome mutagenicity (Ames) test system, **Wytensin** at 200-500 mcg per plate or at 30-50 mcg/ml in suspension gave dose-related increases in number of mutants in one (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes. No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture. In another eukaryotic system, *Saccharomyces cerevisiae*, **Wytensin** produced no activity in an assay measuring induction of repairable DNA damage. Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9.6 mg/kg), suggesting impairment of fertility. Fertility of treated males (9.6 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy.

PREGNANCY: Pregnancy Category C. WYTENSIN® MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN. A teratology study in mice indicated possible increase in skeletal abnormalities when **Wytensin** is given orally at doses 3 to 6 times maximum recommended human dose of 1.0 mg/kg. These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits. However, increased fetal loss has been observed after oral **Wytensin** given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg). Reproductive studies in rats have shown slightly decreased live-birth indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6.4 and 9.6 mg/kg. There are no adequate, well-controlled studies in pregnant women. **Wytensin** should be used during pregnancy only if potential benefit justifies potential risk to fetus.

NURSING MOTHERS: Because no information is available on **Wytensin** excretion in human milk, it should not be given to nursing mothers.

PEDIATRIC USE: Safety and effectiveness in children less than 12 years of age have not been demonstrated; use in this age group cannot be recommended.

Adverse Reactions: Incidence of adverse effects was ascertained from controlled clinical studies in U.S. and is based on data from 859 patients on **Wytensin** for up to 3 years. There is some evidence that side effects are dose-related. Following table shows incidence of adverse effects in at least 5% of patients in study comparing **Wytensin** to placebo, at starting dose of 8 mg b.i.d.

Adverse Effect	Placebo (%) n = 102	**Wytensin** (%) n = 109
Dry mouth	7	28
Drowsiness or sedation	12	39
Dizziness	7	17
Weakness	7	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial. Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time. In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20%. Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less: Cardiovascular—chest pain, edema, arrhythmias, palpitations. Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort. Central nervous system—anxiety, ataxia, depression, sleep disturbances. ENT disorders—nasal congestion. Eye disorders—blurring of vision. Musculoskeletal—aches in extremities, muscle aches. Respiratory—dyspnea. Dermatologic—rash, pruritus. Urogenital—urinary frequency, disturbances of sexual function. Other—gynecomastia, taste disorders.

Drug Abuse and Dependence: No dependence or abuse has been reported.

Overdosage: Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years. Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both. Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic. Vital signs and fluid balance should be carefully monitored. Adequate airway should be maintained and, if indicated, assisted respiration instituted. No data are available on **Wytensin** dialyzability.

Dosage and Administration: Individualize dosage. A starting dose of 4 mg b.i.d. is recommended, whether used alone or with a thiazide diuretic. Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response. Maximum dose studied has been 32 mg b.i.d., but doses this high are rarely needed.

How Supplied: (guanabenz acetate) Tablets, 4 mg, bottles of 100 and 500; 8 mg and 16 mg, bottles of 100.

Revised 2/14/85

Wyeth Laboratories
Philadelphia, Pa. 19101

©1984, Wyeth Laboratories.

Ad Council

TWELVE IMPECCABLE EXCUSES FOR NOT GIVING BLOOD.

"1. I think I have lumbago.
2. I'm type Z negative.
3. I'm on the grapefruit diet.
4. I gave six months ago.
5. I just got back from Monaco.
6. The lines are thirteen blocks long.
7. My mother won't let me.
8. I didn't sign up.
9. I'm going out of town.
10. Asthma runs in my family.
11. I forgot to eat this morning.
12. I'm allergic to flowering magnolia."

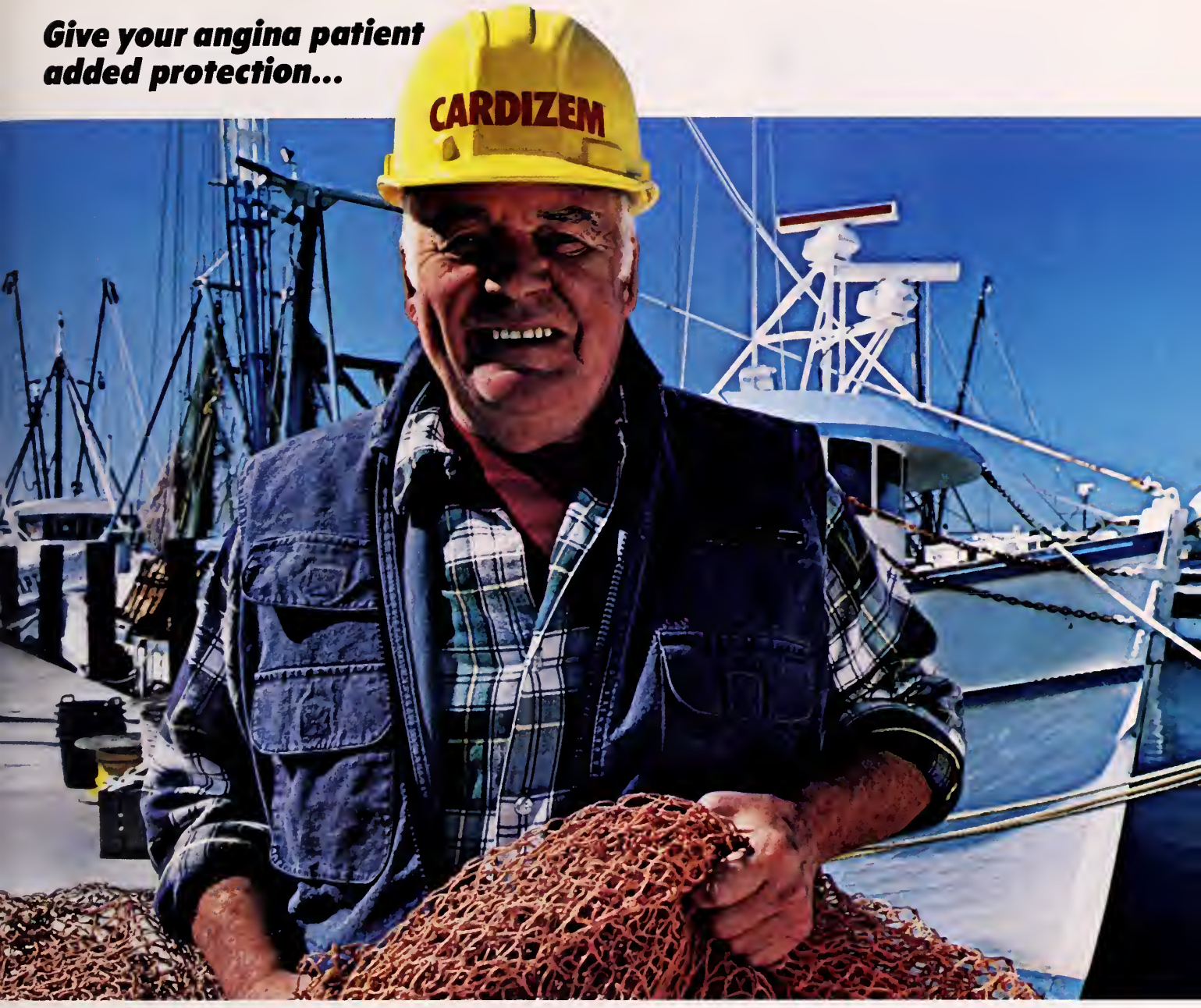


Each one's a doozy, but we're hoping you won't use any of them. Give blood through the American Red Cross. Please, don't chicken out.

EXCUSES DON'T SAVE LIVES. BLOOD DOES.

American Red Cross

Give your angina patient added protection...



CARDIZEM®: FEWER SIDE EFFECTS

diltiazem HCl/Marion

- ***The lowest incidence of side effects among the calcium channel blockers***[1]
- ***An exceptionally safe choice for angina patients with coexisting hypertension, diabetes, asthma, or COPD***[1-3]
- ***Proven efficacy when used alone in angina***[1,4-6]
- ***Compatible with both beta-blockers and nitrates***[7]

Please see brief summary of prescribing information on the next page.



CARDIZEM® 60 mg tid or qid

diltiazem HCl/Marion

FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node retractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence:

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity
Other:	Polyuria, nocturia

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LO_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LO_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LO_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

See complete Professional Use Information before prescribing.

0642T5

References: **1.** *Physicians' Desk Reference®*, ed 39. Oradell, NJ, Medical Economics Company Inc, 1985. **2.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease: A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **3.** Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. *Mod Med* 1982; 50(Sept):94-116. **4.** Subramanian VB: Comparative evaluation of four calcium antagonists and propranolol with placebo in patients with chronic stable angina. *Cardiovasc Rev Rep* 1984; 5:91-104. **5.** Schroeder JS, Feldman RL, Giles TD, et al: Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 1982; 72:227-231. **6.** Weiner DA, McCabe CH, Cutler SS, et al: The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. *Clin Cardiol* 1985; 7:648-653. **7.** Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec):150-159.

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137

BOOK REVIEW

Book Review Editor — F. Norman Vickers, M.D.

A history of the practice of medicine in Manatee County, Florida

By Robert E. King, M.D., 376 pages. Price $20.00 (Hardbound), $15.00 (Paperback). Manatee Memorial Hospital, Bradenton.

> "Another point to which I feel it is my duty to call your attention is the deficiency of medicine. We have but little more than indigenous barks and roots with which to treat the numerous forms of disease to which our attention is daily called. For the treatment of wounds, ulcers, etc. we have literally nothing except water. Our wards — some of them — are filled with gangrene, and we are compelled to fold our arms and look quietly upon its ravages, not even having stimulants to support the system under its depressing influences, this article being so limited in supply that it can only be issued for cases under the knife. I would respectfully call your earnest attention to the above fact, in the hope that something may be done to alleviate the suffering of the sick. I am, Sir, very respectfully your obedient servant,
>
> J. Crews Pelot
> Assistant Surgeon CSA
> Officer of the Day"

This is a portion of a report by a compassionate Confederate surgeon at the hospital of the prison camp at Andersonville, Georgia on September 5, 1864. Pelot was the last Confederate officer to be on duty at this infamous prison; he was relieved by Union medical officers. After the Civil War he moved from his home in Alachua County to Manatee County, Florida to become the first practicing physician there.

Dr. Robert E. King, a native son of Manatee County, leaves a delightful history of Manatee County medicine in a series of biographical sketches. Dr. King has read widely from the printed sources, interviewed old-timers and has had access to archival material of families he grew up with. He delves into the impact of the Seminole Wars, yellow fever epidemics, The Civil War, the Reconstruction Period, World War I, The Great Depression and World War II upon medicine in Manatee County. With photographs as well as written text he protrays the rise of hospitals in that area and the transition to what we today consider modern medicine.

The lay reader will find human interest stories dealing with the medical aspects of frontier life. The physician will find some of the favorite prescriptions of 19th century physicians in that area. Those interested in biography will find a great deal of information not hither to available about 56 physicians, pharmacists and dentists who have played a significant role in medicine in that area of our State.

Dr. King is to be congratulated for this significant contribution to the history of Florida medicine. The book may be ordered from the South Florida Museum, 201 Tenth Street West, Bradenton 33505.

William M. Straight, M.D.
Coral Gables

- Dr. Straight practices internal medicine in Coral Gables and is the former Historical Editor of *The Journal.*

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC. P.O. BOX 2411, JACKSONVILLE, FL 32203 TELEPHONE 904/356-1571

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

We care. . .in many ways

A few weeks ago I sat down to fill out a questionnaire from the AMA-Auxiliary, called "General Activities." When I realized that our county was involved in only three of the 96 projects listed, I felt ill. Then at our District Spring Workshop I learned that other Auxiliaries were having the same problem. The programs are there but where are the workers? I decided to find out whether the main problem was apathy toward the Auxiliary, apathy toward the community, or just plain apathy. I discovered that the answer is "none of the above." All of our members are involved in a variety of community projects, not because they are Auxilians, but because they are concerned citizens. What follows is a brief look at some of the volunteer and professional services provided by Auxilians from all over Florida, and particularly from Lake County.

Neighborhood churches have our caring parents and multi-talented members as Sunday School teachers, youth directors, Children's Church leaders, choir members and musicians. Church librarian and public relations-promotions director also came up in the survey.

Many of our mothers with children in school volunteer their services as teacher's aides, room mothers, field trip escorts, and tutors. Some of our foreign born members go into the schools with special programs about their native countries. PTA projects and school fund raisers always demand attention. We also have School Board members in our midst. In Lake County the weekly newspaper column "School Board Scoop" is written by an Auxilian.

After school hours are frequently devoted to transporting children to and very often leading Girl Scouts, Boy Scouts, YMCA, gymnastics, swimming, and a whole host of other sports activities. We also have volunteers that work for the American Cancer Society, The Arthritis Foundation, The League of Women Voters, and several other organizations. In addition, Auxilians are frequently called on to assist with hospital sponsored health fairs, and many of our members help the blood banks and Hospice centers, as well.

The cultural push to have a career in addition to being a homemaker-volunteer has affected us as much as it has the rest of the world. The Executive Director of the Lake County Medical Society is an Auxilian. We also have nurses, medical office managers, teachers, professors, realtors, travel agents, lawyers, and this year Florida has an Auxilian-lawyer (Joan Wollin) running for Governor.

After completing this survey I could check several more programs on the AMA checklist. That made me feel good. But what made me feel even better was the long list of other "community service projects" that we are involved in. We do care in many ways!

Mrs. Marcos (Susan) Lima
Lake County Medical Auxiliary President
Leesburg

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

29 Glen Cove Ave., Glen Cove, N.Y. 11542 516-676-4300

Our members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
American Health(10)	14.95	12.95	11.95	
American Heritage(6)	24.00	18.00	18.00	
Amer.Photographer(12)	19.90	9.95	6.65	8
Americana(6)	11.95	11.95	9.95	
ArtNews(12)	29.95	25.95	25.95	
Artist's Mag(12)	21.00	21.00	9.97	9
Atlantic Monthly(12)	9.95	9.95	9.95	
Audio(12)	17.94	8.97	8.97	
Baseball Digest(12)	14.95	14.95	7.97	10
Basketball Digest(8)	9.95	9.95	7.97	
#Better Hms-Gdns(12)	12.97	6.49	12.97	
#Bicycling(10)	15.97	8.00	12.97	
Black Enterprise(12)	15.00	9.00	7.50	
Bon Appetit(12)	15.00	15.00	15.00	
Boys Life(12)	13.20	13.20	11.97	
Car & Driver(12)	17.00	11.99	11.99	
Cats (12)	17.50	17.50	12.50	
Cat Fancy(12)	17.97	17.97	12.97	
Changing Times(12)	15.00	9.97	9.97	
Child Life:age 6-10(8)	11.95	11.95	9.97	
Childrens Dig:7-11(8)	11.95	11.95	9.97	
Commentary(12)	33.00	33.00	33.00	
#Connoisseur(12)	19.95	10.00	19.95	
Consumers Digest	14.97	14.97	10.97	
Consumers Reports(12)	16.00	16.00	16.00	
#COSMOPOLITAN(12)	**24.97**	**15.00**	**24.97**	
Cruising World(12)	18.00	18.00	14.00	
#Discover(12)	24.00	13.00	14.95	
Dog Fancy(12)	17.97	17.97	12.97	
Downbeat(12)	15.75	15.75	7.95	
Ebony(12)	16.00	14.00	9.97	
The Economist(52)	85.00	51.00	51.00	
Ellery Queen Myst(13)	22.75	19.50	9.97	10
Esquire(12)	17.94	9.95	9.95	
Essence(12)	12.00	9.96	9.00	
Family Circle(17)	14.97	14.97		
Family Computing(12)	19.97	11.97	11.97	
Family Handyman(10)	9.95	9.95	5.95	
Field & Stream(12)	13.94	7.94	7.94	
Fifty Plus(12)	15.00	11.97	11.97	
Financial World(26)	41.95	24.94	18.95	18
Food and Wine(12)	18.00	9.00	15.00	
Football Digest(12)	12.95	12.95	7.97	10
Forbes(28)	42.00	42.00	28.00	
Fortune(26)	42.00	21.00	21.00	
Games Magazine(12)	15.97	15.97	15.97	
Gentlemens Quart.(12)	18.00	13.50		
Glamour(12)	15.00	12.00		
Golf Digest(12)	19.94	11.97	11.97	
Golf Magazine(12)	15.94	8.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Good Housekeeping(12)	14.97	9.97	14.97	
Gourmet(12)	18.00	13.50	15.00	
#Harpers Bazaar(12)	16.97	8.97	16.97	
Harpers Magazine(12)	**18.00**	**9.97**	**9.97**	
Health(12)	22.00	13.32	11.00	
High Fidelity(12)	13.95	6.98	6.98	
Home(12)	15.00	15.00	15.00	
Home Mechanics (12)	11.94	8.97	8.97	
The Homeowner(10)	18.00	13.97	9.00	
Hot Rod(12)	13.94	8.97	8.97	
House and Garden(12)	24.00	18.00		
#House Beautiful(12)	15.97	7.99	15.97	
Humpty Dumpty:4-7(8)	11.95	9.97	9.97	
Jerusalem Post(24)	18.46	18.46	15.97	
Jet(52)	36.00	30.00	26.00	
Ladies Home Jrnl(12)	20.00	15.00	10.00	
#Life(12)	32.50	16.25	25.00	10
M:Civilized Man(12)	24.00	19.95	17.95	10
Mademoiselle(12)	15.00	12.00		
#McCalls(12)	11.95	11.95	11.95	
Metropolitan Home(12)	15.00	7.50	7.50	
Modern Photography(12)	13.98	7.98	6.99	
#Muney(12)	29.95	15.00	19.95	
Mother Jones(12)	18.00	12.00	12.00	
Motor Trend(12)	13.94	7.97	7.97	
MS Magazine(12)	16.00	10.97	10.97	
The Nation (52)	28.00	28.00	9.95	24
Nation's Business(12)	22.00	12.97	12.97	
Natural History(12)	20.00	15.95	15.95	
N.E.Journal of Medicine(52)	60.00			
New Republic (52)	48.00	48.00	28.00	
#New Shelter(9)	10.97	5.50	9.97	
N.Y. Rev.of Books(17)	28.00	28.00	25.95	
New Yorker(52)	32.00	32.00	20.00	
#Newsweek(52)	41.00	21.80	21.80	
Omni(12)	24.00	15.96	15.96	
1001 Home Ideas(12)	22.00	15.97	11.00	
Organic Gardening(12)	12.97	9.97	9.97	
Outdoor Life(12)	13.94	7.97	7.97	
Outside(10)	16.00	12.00	8.97	
Ovation(12)	16.00	8.00	8.00	
PARENTS(12)	**18.00**	**9.00**	**11.95**	
Penthouse(12)	36.00	30.00	30.00	
People(52)	56.50	56.50	28.25	
Personal Computing(12)	18.00	18.00	8.97	9
Petersens Photog(12)	13.94	6.97	6.97	
Playboy(12)	25.00	21.50	21.50	
#Popular Mechanics(12)	13.97	7.00	13.97	
Popular Photogr.(12)	11.97	5.99	5.99	
Popular Science(12)	13.94	7.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Prevention(12)	13.97	7.00	13.97	
Psychology Today(12)	15.99	8.00	12.97	
Reader's Digest(12)	15.41	15.41	15.41	
#Redbook(12)	11.97	6.97	11.97	
Road and Track(12)	17.94	11.99	12.99	
Rolling Stone(26)	19.95	19.95	17.95	
The Runner(12)	16.97	12.97	8.97	
#Runner's World(12)	19.95	10.00	12.97	
Sail(12)	21.75	21.75	21.75	
Saturday Eve.Post(9)	12.97	12.97	12.97	
Savvy(12)	12.00	12.00	6.00	
Science '86(11)	18.00	18.00	13.95	
#Science Digest(12)	13.97	6.99	13.97	
Scientific Amer.(12)	24.00	24.00	24.00	
Self(12)	15.00	12.00	N.A.	
Seventeen(12)	13.95	13.95	13.95	
Shape(12)	20.00	20.00	8.97	6
Ski(8)	11.94	6.97	6.97	
Skiing(7)	9.98	4.99	4.99	7
Skin Diver(12)	13.94	7.97	7.97	
Sport(12)	12.00	7.97	7.97	
Sporting News(24:6 mo)	22.50	11.97	11.97	
#Sports Afield(12)	13.97	6.99	13.97	
#Sports Illustr.(54)	56.50	34.00	29.45	
Stereo Review(12)	9.97	4.99	4.99	
Teen(12)	12.95	7.95	7.95	
Tennis(12)	17.94	8.97	8.97	
#Time(52)	58.25	29.25	28.00	50
#Town & Country(12)	24.00	12.00	24.00	
Travel & Leisure(12)	25.00	12.50	25.00	
TV Guide(52)	31.20	31.20	26.00	
#U.S.News/Wrld.Rep(52)	41.00	20.50	20.50	
Vegetarian Times(12)	19.95	14.95	14.95	
Video(13)	15.00	15.00	7.50	
Video Review(12)	12.00	6.97	6.97	
Village Voice(52)	32.76	32.76	22.00	
Vogue(12)	24.00	21.00		
W Magazine(26)	26.00	23.00	17.95	
Weight Watchers(12)	13.97	11.97	11.97	
Woman's Day(17)	15.13	15.13	15.13	
Women's Sports(12)	12.95	12.95	8.95	
Workbench(6)	6.00	6.00	5.00	
Working Mother(12)	11.95	9.95	9.95	
Working Woman(12)	18.00	12.00	15.00	
World Press Review(12)	16.95	16.95	14.98	
Writer's Dig.(9 iss)	18.00	9.97	9.97	
Yankee (Colonial)(12)	15.00	15.00	12.97	
YM(12)	14.00	10.95	10.95	

#BUSINESS CARD NEEDED FOR OFFICE PRICE

HUNDREDS OF OTHER TITLES AVAILABLE! PLEASE SEND US YOUR REQUESTS!

FMA MAGAZINE PROGRAM
29 Glen Cove Ave., Glen Cove, N.Y. 11542

MAIL MAGAZINES TO:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AFFILIATED HOSPITAL/SCHOOL _____
Required for Educator rates

VISA or M/C No. _____ Exp. Date _____

Prices subject to publishers' changes

PLEASE SEND THE FOLLOWING MAGAZINES:

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

All subscriptions are for one year unless otherwise noted.
Guarantee: Our prices are the lowest, our service the best.
New Orders: Publishers take from 6 to 12 weeks to start your subscription
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.

Please make checks payable to FMA Magazine Program

FLMD186

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

JUNE

Medicolegal Issues in Obstetrics, June 2-5 and June 16-18, Marriott Hotel, Orlando. Contact: Robert Knuppel, M.D., USF College of Medicine, 12901 N. 30th Street, Tampa 3612, (813) 251-3748.

Viral Hepatitis, June 3, 1986, Holy Cross Hospital, Ft. Lauderdale. Contact: Jon Fichtelman, M.D., 4725 N. Federal Highway, Ft. Lauderdale 33308.

Practical Concepts of Standard and Locked Intramedullary Nailing, June 6, University of Miami, Miami. Contact: University of Miami, Dept. of Orthopedics, P.O. Box 016960, Miami 33101, (305) 549-7081.

Florida Society of Clinical Hypnosis Meeting, June 6-8, Sandpiper Bay, Port St. Lacie. Contact: Linda K. Tower, 1440 N.W. 14th Ave., Miami 33125, (305) 547-2000.

Trauma Workshop, June 6-8, Ocean Reef Hotel, Key Largo. Contact: Good Samaritan Hospital, P.O. Box 3166, West Palm Beach 33402.

Seventh Annual Child Neurology Postgraduate Course, June 9-12, Sonesta Beach Hotel, Key Biscayne. For more information: Oscar Papazian, M.D., 6125 S.W. 31st Street, Miami 33155 (305)666-6511, Ext. 2423.

Physician in Management Seminars I & II, June 9-13, The Antlers Hotel, Colorado Springs. For more info: Sherry Masons, 4830 W. Kennedy Blvd., Suite 648, Tampa 33609, (813) 873-2000.

Basic Trauma Life Support, June 14-15, USF College of Medicine, Tampa. Contact: James Hillman, M.D., (813) 251-6911.

Florida Suncoast Pediatric Conference 1986, June 14-18, Trade Winds Resort, St. Petersburg. For more information: Gilbert Pitisci, M.D., 2506 West Virginia Ave., Tampa 33607, (813) 870-8720.

Trends in the Computerization of the Private Medical Practice, June 18, Radisson Hotel, Orlando. Contact: Jeffrey Masters, (813) 875-2211.

Focus on Epilepsy, June 19-21, Holiday Inn, Orlando. For more info: Anne Orem, (305) 857-7282.

Twenty-second Annual Residents' Day Meeting, June 20-21, University of Miami, Miami. For more Information: University of Miami, Dept. of Ophthalmology, P.O. box 016960, Miami 33101, (305) 326-6032.

Supportive Care of the Cancer Patient, June 20-21, Holiday Inn, Pensacola Beach. Contact: John Bachi, M.D., 1201 W. Moreno Street, Pensacola 32501, (904) 434-4917.

Medical Update of Minority Health Problems, June 23-24, Ramada Inn, Tallahassee. Contact: Alfreda Blackshear, 1215 Lee Avenue, Tallahassee 32303, (904) 878-0229.

Cardiac Function in Health and Disease, June 26-27, Sheraton World Hotel, Orlando. Contact: Rick D. Mace, 500 E. Rollins, #101, Orlando 32803, (305) 897-1575.

FAFP 37th Annual Scientific Assembly, June 26-29, Marriott's Marco Beach Resort, Marco Island. For more information: Martha Moores, 4057 Carmichael Avenue, Suite 229, Jacksonville 32207, (904) 398-5667.

JULY

ACLS Course, July 12-13, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Coronary Heart Disease, July 18-19, Dutch American Hotel, Orlando. For more information: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

Infections in the Immune Compromised Individual, July 19, Tradewinds Resort, St. Petersburg. Contact: Jack Hutto, M.D., (813) 898-7451.

MRI, CT & NM in Clinical Practice, July 21-25, Grand Hotel, Paris, France. Contact: Lawrence Muroff, M.D., USF College of Medicine, 12901 N. 3oth Street, Tampa 33612, (813) 873-2090.

Electrocardiography, July 24-27, Marco Beach Resort, Marco Island. Contact: Henry Marriott, M.D., 601 12th Street, North, St. Petersburg 33705.

Imaging Advances in Medicine, July 28-August 1, Churchill Hotel, London, England. Contact: Lawrence Muroff, USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 873-2090.

AUGUST

ACLS Course, August 1-3, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Second Annual Laser Surgery Training Course, August 12-16, Wyndham Hotel, Orlando. For more information: Patti Devlin, 1414 South Kuhel Avenue, Orlando 32806-2093, (305) 841-5144.

Basic Trauma Life Support, August 8-9, USF College of Medicine, Tampa. Contact: James Hillman, M.D., (813) 251-6911.

Second Annual Laser Surgery Training Course, August 12-16, Wyndham Hotel, Orlando. Contact: Patti Devlin, 1414 South Kuhl Ave., Orlando 32806-2093, (305) 841-5144.

Pediatric-Oriented Advanced Cardiac Life Support, August 22-24, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Strategic and Operational Survival Plans for Office Based Physicians, August 22-24, Orlando Hyatt Hotel, Orlando. For more information: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

ACLS Course (Pediatric), August 22-24, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Emergency Management of Facial, Hand and Soft Tissue Injuries, August 24-28, Ameilia Island Plantation, Amelia Island. Contact: Ira M. Dushoff, M.D., 580 West 8th Street, Jacksonville 32209, (904) 355-0561.

A Stitch in Time, August 24-28, Amelia Island Plantation Convention Center, Amelia Island. For more information: Ira M. Dushoff, M.D., 580 W. 8th Street, Jacksonville 32209, (904) 355-0561.

SEPTEMBER

Doppler Echocardiograph Seminar, September 11-13, Innisbrook Resort, Tarpon Springs. Contact: Ann Connelly, R.N., 300 South Hawthorne Road, Winston-Salem, NC 27103.

Aviation Medical Seminar — For Aviation Medical Examiners, September 18-21, Doral Hotel, Miami. Contact: James L. Harris, M.Ed., P.O. Box 25082, Oklahoma City, OK 73125, (405) 686-4881.

Pediatrics for the Practitioner, Sept. 19, Bay Harbor Inn, Tampa. Contact: Herbert H. Pomerance, M.D., USF Dept. of Pediatrics, 12901 N. 30th Street, Box 15CE, Tampa 33612, (813) 974-4214.

Pediatrics for the Practicing Physician, Sept. 19, 1986, Bay Harbour Inn, Tampa. Contact: H.H. Pomerance, M.D., (813) 974-4214.

Pediatrics for the Practitioner: Update in Hematology and Oncology, Sept. 19, Bay Harbour Inn, Tampa. Contact: H.H. Pomerance, M.D., USF Dept. of Pediatrics, 12901 N. 30th Street, Box 15CE, Tampa 33612, (813) 974-4214.

OCTOBER

Cardio Respiratory Disease, October 1-4, Marriott's Orlando World Center, Orlando. Contact: Patti Devlin — CME Coordinator, Orlando Regional Medical Center, 1414 S. Kuhl Avenue, Orlando 32806-2093, (305) 841-5144.

Fourth Annual Advanced Neuroradiology Seminar, October 9-11, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Fifth Annual Medical Laboratory Immunology Symposium, October 19-22, Holiday Inn Surfside, Clearwater. Contact: Herman Friedman, Ph.D., (813) 974-3281.

Arrhythmias: Interpretation, Diagnosis and Management, Oct. 24-25, Orlando Hyatt Hotel, Orlando. Contact: Deborah Wilderson, 5808 S. Rapp Street, #202, Littleton, CO 80120 (303) 798-9682.

NOVEMBER

Neonatal and Pediatric Respiratory Disease Conference, November 6-9, Holiday Inn Sufside, Clearwater Beach. Contact: R.L. Siegel, M.D., USF College of Medicine, 12901, N. 30th Street, Tampa 33612, (813) 972-3131.

Bryant Bureau

The Recruiting and Placement Specialists

Physician Staffing Needs Full Time or Locum Tenum

The Best Source for Qualified Physicians in Florida

Suite 308, Colonial Bldg., 16201 S.W. 95th Ave., Miami, Fla. 33157 (305) 252-1949

University of Miami
School of Medicine
Department of Medicine

REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE

May 12-16, 1986

Key Biscayne Hotel & Villas
Key Biscayne, Florida

A course especially designed for physicians who are preparing for board certification or recertification in Internal Medicine.

State of the Art Lectures

—

Meet the Faculty Sessions

—

Patient Management Problem Sessions

—

Audiovisual Aids

—

Self-assessment Questionnaire Sessions

—

Pictorial Quizzes • Printed Materials

—

39.5 Hours of AMA Category I Credit

Registration: $325 (before March 30, 1986)
$350 (after March 30, 1986)

For registration and information write to:

J. Bocles, M.D., Department of Medicine (R760), University of Miami School of Medicine, P.O. Box 016760, Miami, Florida 33101. Phone: (305) 547-6063.

THE APPROPRIATE GIFT FOR
AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

City & State _____

Dr. _____

Street _____

City & State _____

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name:_____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.,* P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word.
Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

FAMILY PRACTICE opportunity: South Miami area. Board eligible or certified preferred. Excellent pay and working conditions. Affiliated with major medical center. Full or part-time. Respond with C.V. to Box C-1306, P.O. Box 2411, Jacksonville, FL 32203.

PRIMARY CARE CENTERS IN FLORIDA, NEW YORK, NEW JERSEY: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full time basis. Positions available in Central and South Florida coastal communities, central and northern New Jersey, and Long Island, New York area. Guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 930 South Harbor City Blvd., Suite 307, Melbourne, FL 32901.

DIAGNOSTIC RADIOLOGIST North Orlando area - private clinic approximately 15 to 20 hours per week. Flexible arrangement. Reply to C-1323, P.O. Box 2411, Jacksonville, FL 32203.

DIAGNOSTIC RADIOLOGIST, Board Certified needed to join rapidly expanding hospital based solo-practice. Must have angiography/special procedures training/experience. Personable, willing to practice hands-on radiology. Large hospital located on the west coast of Florida, well equipped, MRI Pending. Box C-1329, P.O. Box 2411, Jacksonville, Fl. 32203.

OB/GYN — If you are a board certified or finishing resident who might be interested in a rewarding professional practice, give Murphy, N.C. serious consideration. Murphy Medical Center is a six year old, 50 acute care bed facility which serves a seven county population of 100,000+. Located in the foothills of the Smokey Mountains, Murphy offers the advantages of a small-town life-style, with numerous outdoor activities, without the sacrifice of urban advantages. Attractive first year financial guarantee is available. For more information write or call: CEO, Murphy Medical Center, 2002 U. S. Highway 64 East, Murphy, N.C. 28906, (704) 837-8161.

OB-GYN WANTED: To join 14-man multi-specialty group. Must be board certified or board eligible. Competitive salary and excellent fringe benefits. Send CV reply to Medical Arts Clinic, Inc., 301 West Liberty, Farmington, MO 63640, Attention: Ronald G. Stevens, Adminitrator, or call (314) 756-6751.

FAMILY PHYSICIAN: Board eligible; for West Palm Beach practice. Florida license necessary. Opportunity for future partnership. 305-967-0234 Send C.V. to Benedicto San Pedro, M.D., 3444 S. Congress Ave., Lake Worth, FL 33461..

FAMILY PRACTICE PHYSICIAN — ORLANDO. Family physician for primary care centers serving migrant and indigent families. Good salary and benefits. Equal opportunity. Send C.V. to Gil Walter, P.O. Box 1249, Apopka, FL 32703, or call collect (305) 889-8427.

EMERGENCY PHYSICIAN for hospital E.D. in Central Florida seeing 18,000 patients. Prefer U.S. trained. Direct contract. No agency. Competitive renumeration. 42 hour week. Insurance paid. Three weeks vacation. CME reimbursed. Respond with C.V. to Box C-1328, P.O. Box 2411, Jacksonville, Fl 32203.

UROLOGIST needed with Florida license to join large fully equipped clinic in Pasco County the 7th fastest growing county in the United States. Send C.V. P.O. Box 36, New Port Richey, Florida 33552.

ORTHOPEDIC SURGEON needed with Florida license to join large fully equipped clinic serving a rapidly growing West Coast Florida community. Send C.V. P.O. Box 36, New Port Richey, Florida 33552.

A WEEK, A YEAR, A CAREER — Practice opportunities in Jacksonville, Miami, Orlando, Daytona Beach, Tampa. Options for permanent and/or locum tenens placements in all specialties. Trial associations with established practices in a variety of clinical settings. Call Suzanne J. Anderson at 800-833-3465 or write: Medstaff, Inc., P.O. Box 15538, Durham, NC 27704.

VACANCY AVAILABLE in Tallahassee for a Senior Physician in State Agency Social Security Disability Determinations. Must be licensed in Florida. Internist with EKG interpretation capability preferred. Forty hour week; no night work; holidays and weekends free. No direct patient care. Contact Bill Odom, Area Manager, 2562 Executive Center Circle, East, Montgomery Building, Tallahassee, FL 32301, (904) 488-9060.

FT. PIERCE, FLORIDA — Full time emergency department position available in a 240 bed hospital with an annual ED volume of 24,000. Candidate must be board prepared in emergency medicine. The hospital is centrally located between Disney World and Miami on Florida's Treasure Coast. Excellent compensation and malpractice insurance provided. Please send CV to Cheree Richards, EMSA, 8200 W. Sunrise Blvd., Plantation, FL 33322, or call (305 472-6922.

TAMPA, FL — Excellent opportunity for a Board Certified or Board Eligible Family Practitioner. Immediately available. Excellent compensation and fringe benefits. The individual should be highly motivated and dedicated to the delivery of quality health care. Private Practice setting. Send C.V. to John Q. Stauffer, M.D., 2919 Swann Avenue, Suite 205, Tampa, FL 33609, or call 813-870-3971.

CARDIOVASCULAR THORACIC SURGEON with Florida license needed to join large fully equipped Clinic serving a rapidly growing West Coast Community. Send CV to P.O. Box 36, New Port Richey, FL 33552.

INTERNIST with Cardiology and Pulmonary experience needed to join large fully equipped Clinic serving rapidly growing Florida West Coast Community. Must have Florida License. Send CV to P.O. Box 36, New Port Richey, FL 33552.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

General, thoracic and vascular surgeon wanted to join busy solo practitioner. Lovely Central Florida community with 500 bed hospital. Call (815) 299-7902 Monday-Friday 9:00-4:30 p.m.

N.W. FLORIDA, OB-GYN, BC/BE to join an expanding busy solo practice in the FL Panhandle on the Mexican Gulf Coast's most beautiful beaches. Metropolitan area of 280,000. Salary and benefit package leading to partnership. Please reply with CV to Linda H. Ferguson, 5120 Bayou Blvd., Suite 11, Pensacola, FL 32503.

E.R. FULL TIME OR part-time: East Coast — Community hospital, 12000 visits/year, excellent opportunity for board prepared/certified, E.M. or primary care specialty with E.R. experience. Excellent salary, small group and easy to arrange schedule, needed immediately. Call 672-4791 or 677-9183.

OB-GYN NEEDED — productive and rewarding practice located in beautiful lake/river area of Florida needs third Ob-Gyn for potential partnership. Please respond to C-1335, P.O. Box 2411, Jacksonville, FL 32203.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

ST. PETERSBURG, FL: Emergency Department physician. 42 hours per week. Nights and week-ends. Excellent compensation. Send C.V. to: Diane, P.O. Box 12077, St. Petersburg, FL 33733.

FAMILY PHYSICIAN or general internist to join busy Family Practice in Miami area. Associated with modern Medical Center. Board eligible or certified preferred. Pleasant working conditions. Call or send CV to: Ira S. Jacobson, M.D., 1190 N.W. 95th Street, Suite 1108, Miami, FL 33150, (305) 836-6221.

OPHTHALMOLOGIST: wanted retired non-surgical ophthalmologist with Florida license to join large multi-specialty group practice. Send CV to C-1337, P.O. Box 2411, Jacksonville, FL 32203.

VACANY AVAILABLE in Tallahassee for a Senior Physician in State Agency Social Security Disability Determinations. Must be licensed in Florida. Internist with EKG interpretation capability preferred. Forty hour week; no night work; holidays and weekends free. No direct patient care. Contact Bill Odom, Area Manager, 2562 Executive Center Circle, East, Montgomery Building, Tallahassee, FL 32301 (904) 488-9060.

PEDIATRICIAN — multi-specialty group in East Central Mississippi with three other pediatricians. Excellent fully equipped hospital, JCAH accredited. BC/BE. Initial salary with later productivity based income. Partnership in two years. No HMO/PPO affiliations. Send CV to Kenneth J. Reid Jr., M.D., Rush Medical Group, P.A., 1314 19th Avenue, Meridian, MS 39301.

GROWING PRIMARY CARE Center on east coast central Florida needs a full time physician. Send CV to P.O. Box 524, Rockledge, FL 32955, or call Mrs. Moore, (305) 639-1601.

GENERAL & VASCULAR Surgeon: Daytona Beach — Join surgeon who is retiring in one (1) year — take over practice. Excellent opportunity for July '86. Must be Board Certified. Send CV to Box C-1334, P.O. Box 2411, Jacksonville, FL 32203.

WANTED: A GENERAL SURGEON and urologist with in depth training in surgical urology and office urology to associate with D.O. on the west coast of Florida in active urological and general surgical practice. Please mail curriculum vitae with recent photograph to B. Warren Smith, D.O., 10333 Seminole Blvd., Largo, FL 33540.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

MEDICAL EXECUTIVE DIRECTOR (Psychiatrist) — Exciting opportunity for an innovative psychiatrist to direct a 32-bed psychiatric hospital for adults and adolescents. Hospital corporation is part of a highly regarded, comprehensive system of mental health programs serving Tampa, a beautiful and booming "Megatrend" city on Florida's west coast. New hospital to be built in 1986. The Medical Executive Director will recruit additional psychiatrists to round out the existing multi-disciplinary team and will be responsible for inpatient treatment programs. This person will also serve as Director of Psychiatric Services for outpatient programs in affiliated corporations. Possibility of affiliation with University of South Florida and opportunities for corporate and industrial consultation if desired. Qualifications: Board certified/eligible, excellent clinical and administrative abilities, and eligibility for Florida medical license. Put your creative clinical and managerial ideas to work! Salary competetive. Write or call Dr. Anthony Broskowski, Northside, 13301 N. 30th Street, Tampa, FL 33612, (813) 971-0192.

MEDICAL DIRECTOR — Primary Health Care Division to render medical leadership and medical management to an expanding network of Primary Care Centers. Qualifications: Graduate of an accredited medical college, board certified, Florida licensure required, clinical administrative experience, salary negotiable. Civil Service benefits. CV to Henry R. Thompson, Director, Primary Health Care, Governmental Center, 115 S. Andrews Ave., Ft. Lauderdale, FL 33301.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4204.

TWO POSITIONS AVAILABLE immediately. Excellent opportunity for Family practitioner/Internist. BC/BE in west coast Florida. Im mediate appointment with excellent salary, benefits and profit sharing. Reply in con fidence to Oneco Medical Center, Attn. B.A. Hooli, P.O. Box 1486, Oneco, FL 34264.

Situations Wanted

LOCUM-TENENS: RADIOLOGIST, Board Certified, un;iversity trained with academic background, age 47, experienced in most modalities, will consider office and/or hospital-based practice. Please write C-1311, P.O. Box 2411, Jacksonville, FL 32203.

FMG, ABIM, Gastroenterologist - University trained. Seeking practice opportunity in solo or group in Florida and South East United States, starting July 1986. Would consider other locations. C-1326, P.O. Box 2411, Jacksonville, FL 32203.

PHYSICIAN ASSISTANT: Board certified, 36, 7 years experience in family practice and acute care. Personable, enthusiastic, motivated. Practice management skills. Guaranteed to build practice, increase net income. $175K/yr. ave. gross. Reg. salary pkg. with equity sharing. Prefer coastal S.E. U.S., private sec tor. Robert White, PA-C, 4214 Redwood Ave., Jacksonville, FL 32207, (904) 731-9079.

EXPERIENCED F.P., Board Recertified, Fellow AAFP, Florida licensed, wants association, partnership or a practice in Florida. C-1319, P.O. Box 2411, Jacksonville, FL 32203.

CARDIOLOGIST: Completed 3 years in internal medicine and 2 years in cardiololgy at the University of Miami. Will complete a year of cardiac catheterization and PTCA at the Miami Heart Institute in June 1986. Board certified in IM. Florida licensed. Wants Association, partnership, or a practice in West Palm Beach-Jupiter area. Ricardo A. Bedoya, M.D., 601 Alcazar Ave., Coral Gables, FL 33134.

HEMATOLOGIST also with training in Blood Bank seeking hospital-based practice or group practice. CV and recommendations upon request. C-1336, P.O. Box 2411, Jacksonville, FL 32203.

OB-GYN desires to relocate. Florida East Coast. West Palm to Melbourne only. Twenty years experience with no malpractice. Excellent Florid references. Hard worker. Practice state of art. John N. Canton, M.D., 913 First Colonial Road, Virginia Beach, Virginia 23454 (804) 428-0700.

LOCUM TENENS: Board Certified anesthesiologist: 30+ years experience. Florida license, malpractice coverage. Call (904) 799-3104 or (904) 596-0729.

WELL TRAINED BOARD certified female internist — seeks to buy established practice, internal medicine or family practice, in Florida starting June '86. C-1332, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

RETIREMENT MINDED OB-GYN in north Florida look ing for partner in practice grossing 400,000 t. Partnership immediately with transfer of practice in two years. C-1316, P.O. Box 2411, Jacksonville, FL 32203.

BEAUTIFUL LAKELAND, FL: Solo family practice and 1,876 square foot office, furnishings and equipment. Four examining rooms, x-ray, lab, EKG, efficiency apart ment. Seven hundred bed open staff hospital. Phone 1-813-646-2734.

PSYCHIATRIST with psychoanalytic orientation and forensic subspecialty seeks associate, new or established M.D., board certified or eligible, with FL license to join and/or buy established 13 year psychiatric practice, located in metropolitan Tampa Bay area. Willing to consider creative options with view toward retirement. Terms flexible, negotiable. Dr. P. Callahan, P.O.B. 1686, Largo, FL 34294. (813) 584-4275 24 hrs.

FOR SALE: OB/GYN prac tice. Physician retiring. Last year grossed $170,000, which could be doubled. Office located next to hospital. All modern equipment. N.C. malpractice insurance is $14,000. Call afternoons (919) 892-4131.

PEDIATRIC PRACTICE: (BCBE) in rapid growth area of Central Florida. Busy, well established, fully equipped practice. Terms negotiable, will introduce. Fla. license. C-1325, P.O. Box 2411, Jacksonville, FL 32203.

INTERNAL MEDICINE/CARDIOVASCULAR DISEASES: Growing solo practice in prestigious Kendall area of Miami. Next to 400 bed hospital with open heart program. Much equipment possibly available. Trained staff and pleasant patients will make transition easy. Grosses over $200,000/year. Inquiries: Doctor, Box 365, Miami, FL 33243-0365.

UROLOGY PRACTICE: Well-established, fully equipped, located on southeast coast in attractive office park near two excellent hospitals. Will introduce and assist in transfering patient care. Reasonably priced. Mr. Harold Kwart, Professional Consultant (305) 751-0580.

PSYCHIATRIST with psychoanalytic orientation and forensic subspecialty seeks associate, new or established M.D., board certified or eligible, with FL license to join and/or buy established 13 yr. psychiatric practice, located in metropolitan Tampa Bay area. Willing to consider creative options with view toward retirement. Terms flexible, negotiable. Dr. P. Callahan, P.O.BV. 1686, Largo, FL 34294. (813) 584-4275 24 hrs.

FLORIDA WEST COAST: Splendidly located, freestanding clinic for family practice or walk-in. Laboratory and x-ray. Rapidly expanding community. Nearby accredited hospital. Annual gross over 400,000.00. C-1321, P.O. Box 2411, Jacksonville, FL 32203.

PRIVATE PRACTICE available, Florida's Space Coast. Same location for 28 years across from Ocean. Fully equipped office, lab X-ray & EKG. Hospital staff available. Retiring will introduce. High income potential. Contact: L.R. Wells, M.D., 2210 S. Atlantic Ave., Cocoa Beach, FL 32931.

FOR SALE: General internal medicine practice. Florida Gulf Coast. Net income over 100K. Price of $17,000 includes office furniture and some equipment. Available June, 1986. C-1331, P.O. Box 2411, Jacksonville, FL 32203.

FT. LAUDERDALE Radiology office building and equipment for sale. Siemens, Kodak and Technicare. (305) 771-9500 or (305) 942-2946.

FOR LEASE: Fully equipped medical facility. Complete lab, x-ray, orthopedic and surgery departments. Suitable for solo or group practice. Will consider lease with option to buy. Contact J. Davis, P.O. Box 25337, Sarasota, FL 34277.

FOR SALE — Ft. Lauderdale. Busy Internal Medicine Practice, 5 years old, 2 office locations, physician relocating. Call Dr. West, 791-3278 after 9:00 p.m.

NAPLES, FL, Urologist retiring. Desires to sell desirable office building and equipment. Will give good terms to qualified urologist. Call 813-262-1521 or 813-262-3996.

UNOPPOSED GYNECOLOGICAL Practice for sale. Downtown Miami. Grossing $300,000.00 plus yearly. Efficient staff speaking English, Spanish and Creole. Will stay on. Terms negotiable.

Real Estate

SPRING HILL, FL - 2300 square foot professional of fice space in modern new prestigous building with prime exposure. For sale or lease - owner will finance. (904) 596-4162 weekdays.

HANDSOME SECOND INCOME: Franchise starting in Florida to physicians and dentist only; do not miss this opportunity call Bob Richardson (305) 977-9322.

CAYMAN ISLANDS — modern 2 bedroom beach house on Cayman Brac. Superb snorkelling and scuba. Quiet out-island setting. Rental $350.00 per week. Dr. R. Lament, 2187 West 4th Avenue, Vancouver B.C. Canada (604) 733-5722.

FUTURE OFFICE SPACE: Available June 1986. Prime location north St. Petersburg. Will build to suit. Free standing professional building. George Stovall, (813)896-5371.

PHYSICIAN OWNER MUST SELL new fully furnished ocean front condo at Seawatch (Vilano Beach). On ocean, pool, tennis, covered parking. 2 bedroom, 2 bath. Price reduced. Phone (305) 278-1063.

PROFESSIONAL OFFICE SPACE: Prestigious community of Sarasota. 1600 sq. ft. Previous tenant busy M.D. Turn key ready. 813-921-5521 or 813-923-7103.

POSITIVE CASH FLOW. Excellent Investment. Pre-leased two-story office building in superrb location on Main Street in the heart of Sarasota's rapidly developing downtown complex. 2400 square feet. Tenant will manage building for owner. Call (813) 366-7935.

VERO BEACH, FL — (East Coast — 1 hour north of Palm Beach) Lesase or Purchase — oustanding new medical offices at hospital. Pre-completion prices and lease rates. Call for color brochure. Doug Anderson, Associate, Sheraton Commercial Properties, Inc. (305) 231-6144.

DOCTOR MUST SELL new luxury prime condo, Park Plaza, 12th Floor. Three bedroom, two bath. Covered parking, pool, magnificent view St. Johns River and downtown Jacksonville. Dock available. Price reduced. Phone: (305) 278-1067.

TWENTY-SIX ACRES of beautiful mountain land, includes four streams, level farmland with bvarn, Robbinsville, N.C., near resorts. Ideal for development or dwelling. $40,000 (904) 733-1215 or (214) 234-6040.

OFFICE FOR RENT. 1320 Square feet in medical building with five other specialists. Excellent location. Call (305) 295-4644.

MY FREE-STANDING optometric office of 24 years is for lease, 2700 squre feet, ½ mile to Memorial Hospital, personal off-street parking, 6817 Beach Blvd., R. H. Miller, O.D., 725-5076.

COLORADO - Picturesque mountain ranch home for rent. Comfortable any season. All outdoor activities. Adjacent wilderness area. Also 3 lovely building sites available. Brochure. Thomas Beach, M.D., (904) 387-7300.

Services

ATTRACT NEW PATIENTS to your practice! The Marketing Guide for Physicians provides working knowledge and successful techniques to promote your practice. $6.50/copy. Order from The Pennsylvania Medical Society's Trust, 20 Erford Road, Lemoyne, PA 17043. Other publications also available.

MEDICAL RESEARCH OPPORTUNITIES in U.S.A. and Canada for M.D.'s and Ph.D.'s or foreign equivalent degree holders in medical or health related areas. Contact National Medical Researcher Matching Program, P.O. Box 2079, Boise, ID 83702.

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, promptservice. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

FINANCIAL SHELTERS IN Switzerland. Legal, secure, strictly confidential. For Information write: Assurex, S.A., P.O. Box 209-R, Volkmarstrasse 10, 8033, Zurich, Switzerland.

ATTENTION PHYSICIANS in South Florida who have non-ambulatory patients in nursing homes or private homes. We are a portable x-ray service licensed and certified in South Florida. All your radiographs are interpreted by a Board Certified Radiologist with a written report sent promptly to your office. Medicare accepted. Reliable Radiographic Services 755-3349.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and preowned medical instrumentation: Holter-Stress-Ultrasound-EKG Lab etc. Contact New Life Systems, Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065; 305-972-4600.

Equipment

FOR SALE — Complete office billing computer system. BC/BS Software, tape back-up, 20 medgabyte hard disc, direct transmission for BC/BS Claims, new printer. Reasonably priced or best offer, call (813) 546-2571, 8-6, Mon.-Fri.

Meetings

BIOFEEDBACK THERAPIST TRAINING PROGRAM - Six day program (2-3 day weekends) to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. CEU's Available. Jan. 17-19 & Jan. 24-26, or March 1-3 & March 15-17, or May 16-18 & May 30-June 1, or July 11-13 & July 25-27, 1986. For brochure con tact: Hartje Stress Clinic, 2429 University Blvd., West., Jacksonville, FL 32217. (904) 737-5821.

MAY 1-4, FLORIDA SPEECH, Language, and Hearing Association (FLASHA) Spring Convention, Jacksonville, Florida. Con tact: Tim Stavropulos, 5720-1 Atlantic Boulevard, Jacksonville, Fl. 32207. (904) 725-4646. ASHA continuing education credits available.

FIRST STATE MARKETING Workshops for M.D.s have been scheduled May 16, Sheraton Maitland, Orlando. Sessions in afternoon 2-5 covering components of Medical Marketing with Dr. Jacques Caldwell, Daytona Beach; marketing, writer/editor and advertising/ publications. Private workshop for M.D.s will be held 7-9 p.m. Evaluation, personal problems and planning will be covered. Sponsored by Health Care Communications Inc. of Dade County, first Florida firm to work fulltime in specialty. Course designed for solo and group practices, joint ventures, free-standing clinics. Day, evening fees $55 each, $110 total. For program call 1-800-851-3392. Workshops arranged Saturday or evenings throughout state. Details call Larry Strum, HCC, 305-274-0999 . . . 18 years community and major medical centers.

"Deafness is something you put beside you, not in front of you."

Believe in them. Break the barriers.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, WASHINGTON D.C. 20210

Physicians' Confidential Assistance

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

THE FLORIDA MEDICAL FOUNDATION 1956

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians



How to live with someone who's living with cancer.

Learning to live with cancer is no easy task. Learning to live with someone else's cancer can be even more difficult.

Nobody knows better than we do how much help and understanding is needed. That's why our service and rehabilitation programs emphasize the whole family, not just the cancer patient.

We run local programs with volunteers who are recovered cancer patients, or whose lives have been touched by family members or friends with cancer. That's what makes us one of the largest, best-motivated and most caring of any health organization in the country.

Among our regular services we provide information and guidance to patients and families, transport patients to and from treatment, supply home care items and assist patients in their return to everyday life.

Life is what concerns us. The life of cancer patients. The lives of their families. So you can see we are even more than the research organization we are so well known to be.

No one faces cancer alone.

AMERICAN CANCER SOCIETY®

YOUR NEW LOW DAILY RATES AT AVIS START AT $33.00



Avis features GM cars. Buick Century.

Your association membership means new, uniform low flat rates at Avis. And there's no charge for mileage. Choose from subcompact through full size 4-door car groups:

DAILY RATE	
SUBCOMPACT (Chevrolet Chevette or similar)	**$33.00**
FULL SIZE 2-DOOR (Buick Century or similar)	**$39.00**

These uniform low flat rates make it easy to know your rate before you go. To reserve a car, call Avis toll free: ***1-800-331-1212***

Be sure to mention your Avis Worldwide Discount number: **A/A616900.**

AVIS® ***WE TRY HARDER.®***

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. Flat rates are nondiscountable and are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. An additional charge per day will apply in certain locations including Newark Airport, NJ; LaGuardia Airport, NY; Kennedy Airport, NY; and all Manhattan locations. Check with Avis for the amount. Rates, discounts and additional charges subject to change without notice. Cars must be returned to rental location or higher daily rate and a one-way service fee will apply. Cars and particular car groups subject to availability. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

© 1985 Avis Rent A Car System, Inc., Avis®

ADVERTISERS

Air Force Reserves
Recruitment 414

Army
Recruitment 400

Army Reserves
Recruitment 376

Ayerst Laboratories
Inderal LA 358b
Inderide LA 358c

BellSouth Mobility
Service 375

Brown Pharmaceutical
Android 369
Lipo-Nicin 405

Bryant Bureau
Service 421

Curtis 1000 Information Systems
Computers 358e

Digit-Up
Service 414

Eli Lilly & Company
Keflex 386

FMA Sponsored Insurance Plans
Service 362

Florida Physicians' Insurance Company
Service 358

GTE Telenet
Service 416

Info Systems
Computers 406

Janssen Pharmaceutica
Vermox 414

Knoll Pharmaceutical Company
Isoptin 406b
Vecodin 358e

Marion Laboratories, Inc.
Cardizem 414e

Medical World News
Publication 369

Roche Products, Inc.
Dalmane 431

Shari Medical Center
Recruitment 359

Smith Kline & French Laboratories
Dyazide 406a

University of Alabama
Service 398

University of Miami
Meeting 405, 421

Upjohn Company
Motrin 414a

Willingway Hospital
Service 406

Wyeth Laboratories
WyTensin 414b

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D., Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

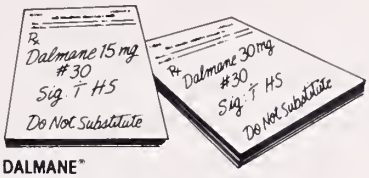
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
brand of
flurazepam HCl/Roche Ⓝ
sleep that satisfies

15-mg/30-mg
capsules



References: 1. Kales J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. **2.** Kales A, *et al. Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al. Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD. *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al.* Symposium on the Treatment of Sleep Disorders, Telecanterence, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
brand of
flurazepam HCl/Roche Ⓝ

Before prescribing, pleose consult complete product informotion, o summory of which follows:

Indicotions: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Wornings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precoutions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reoctions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosoge: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see preceding page for summary of product information.

DALMANE®
brand of
flurazepam HCl/Roche ℞
sleep that satisfies



COLL.OF PHYS.OF PHILADELPHIA
LIBRARY
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

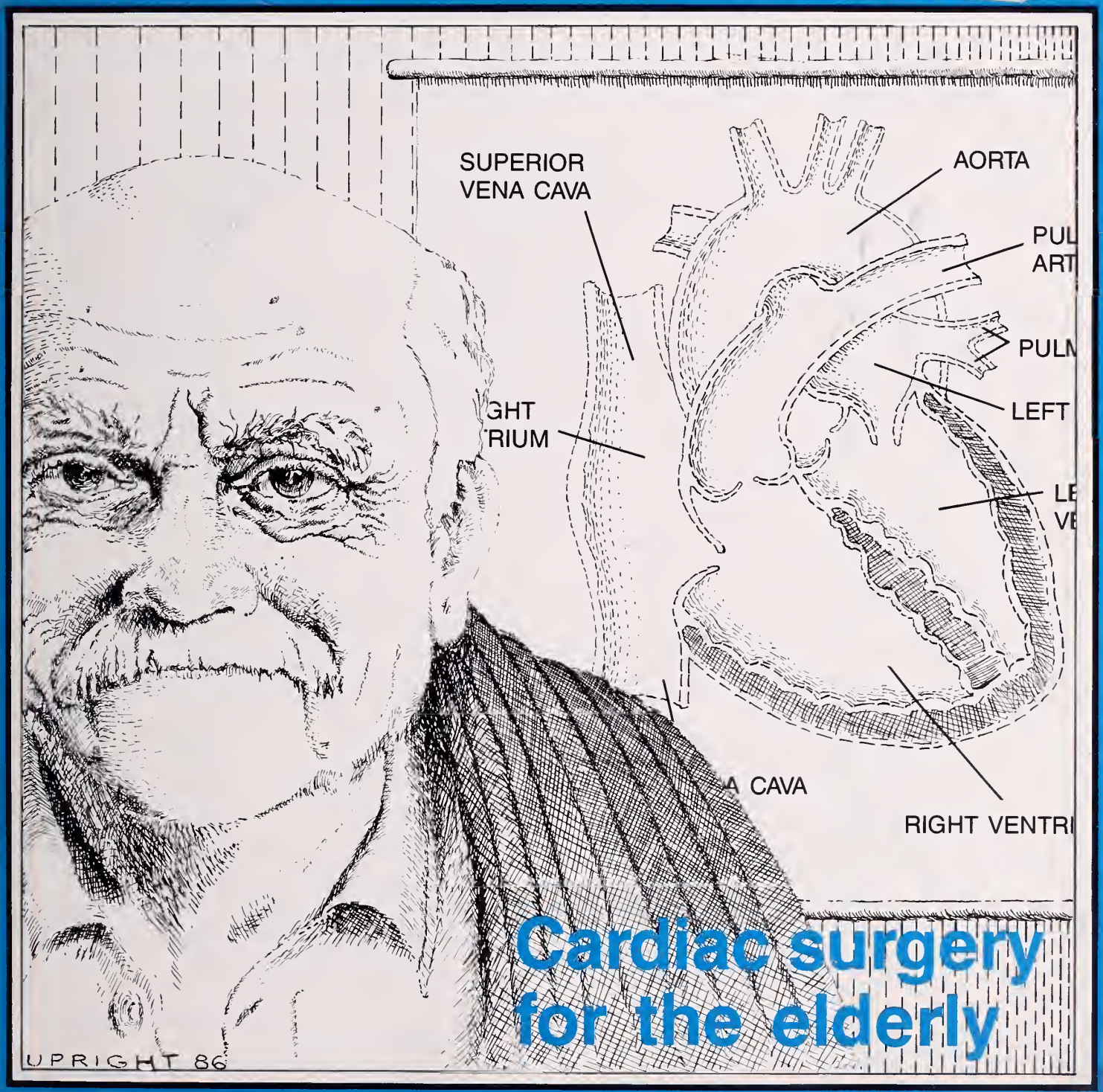
Copyright © 1986 by Roche Products Inc. All rights reserved.

ROCHE®

BACKS

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. JUNE 1986, Vol. 73, No. 6

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
M.D.S.
JUL 3 - 1986



Cardiac surgery for the elderly

Select Quality!

The chart on this page can be used to compare the advantages of insuring with Florida Physicians Insurance Company. All medical professional liability insurance coverage is NOT the same!

QUESTION	FPIC	PPTF	ST. PAUL
Are your carrier's premiums non-assessable ?	YES	NO	YES
Is your carrier medical association sponsored ?	YES	NO	NO
Is your carrier Florida owned and operated ?	YES	YES	NO
Is the majority of your carrier's Board of Directors made up of physician's ?	YES	YES	NO

For more information call Ron Gladman:

FPIC FLORIDA PHYSICIANS INSURANCE COMPANY

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

10 YEARS

Thank you for your loyal support



DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

SK&F CO.


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2406

EMPLOYEES APPRECIATE THE PAYROLL SAVINGS PLAN.

JUST ASK THE PEOPLE AT THE BOEING COMPANY.

"My folks gave me a Bond for my birthday every year. Now I can do the same for my kids."
—Vaughn Hale



"It's certainly a painless way to save. The money comes directly out of my paycheck every two weeks."
—Florence Perry

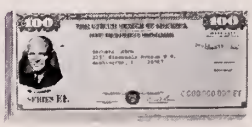


"This is one way I can support my government and save at the same time."
—Douglas Scribner



U.S. Savings Bonds now offer higher variable interest rates *and* a guaranteed return. Your employees will appreciate that. They'll also appreciate your giving them the easiest, surest way to save.

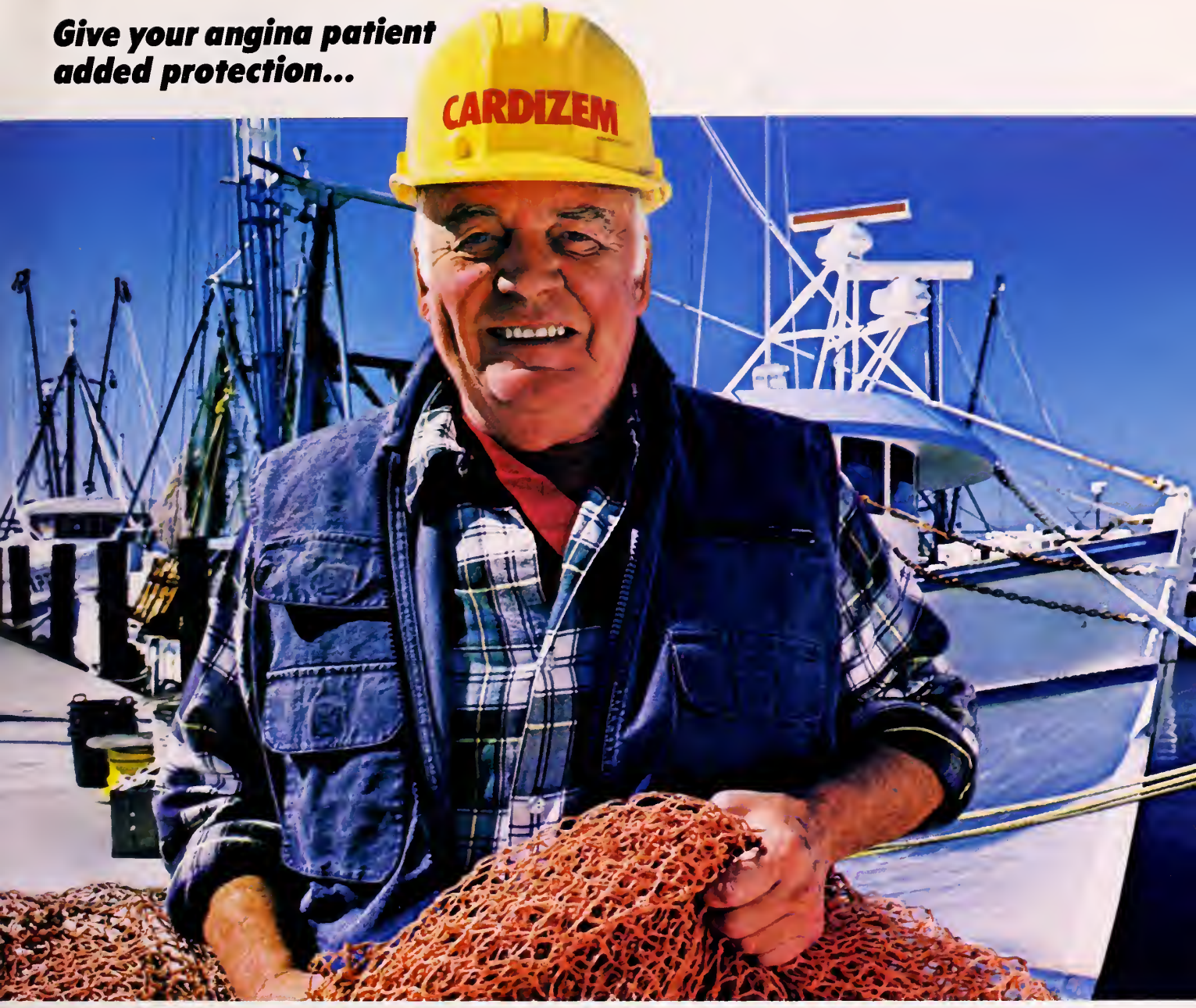
For more information, write to: Steven R. Mead, Executive Director, U.S. Savings Bonds Division, Department of the Treasury, Washington, DC 20226.



U.S. SAVINGS BONDS
Paying Better Than Ever

A public service of this publication.

Give your angina patient added protection...



CARDIZEM®: FEWER SIDE EFFECTS

diltiazem HCl/Marion

- ***The lowest incidence of side effects among the calcium channel blockers[1]***
- ***An exceptionally safe choice for angina patients with coexisting hypertension, diabetes, asthma, or COPD[1-3]***
- ***Proven efficacy when used alone in angina[1, 4-6]***
- ***Compatible with both beta-blockers and nitrates[7]***

Please see brief summary of prescribing information on the next page.



CARDIZEM® 60 mg tid or qid

diltiazem HCl/Marion

FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence:

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGDT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme, leukopenia, and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LO_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

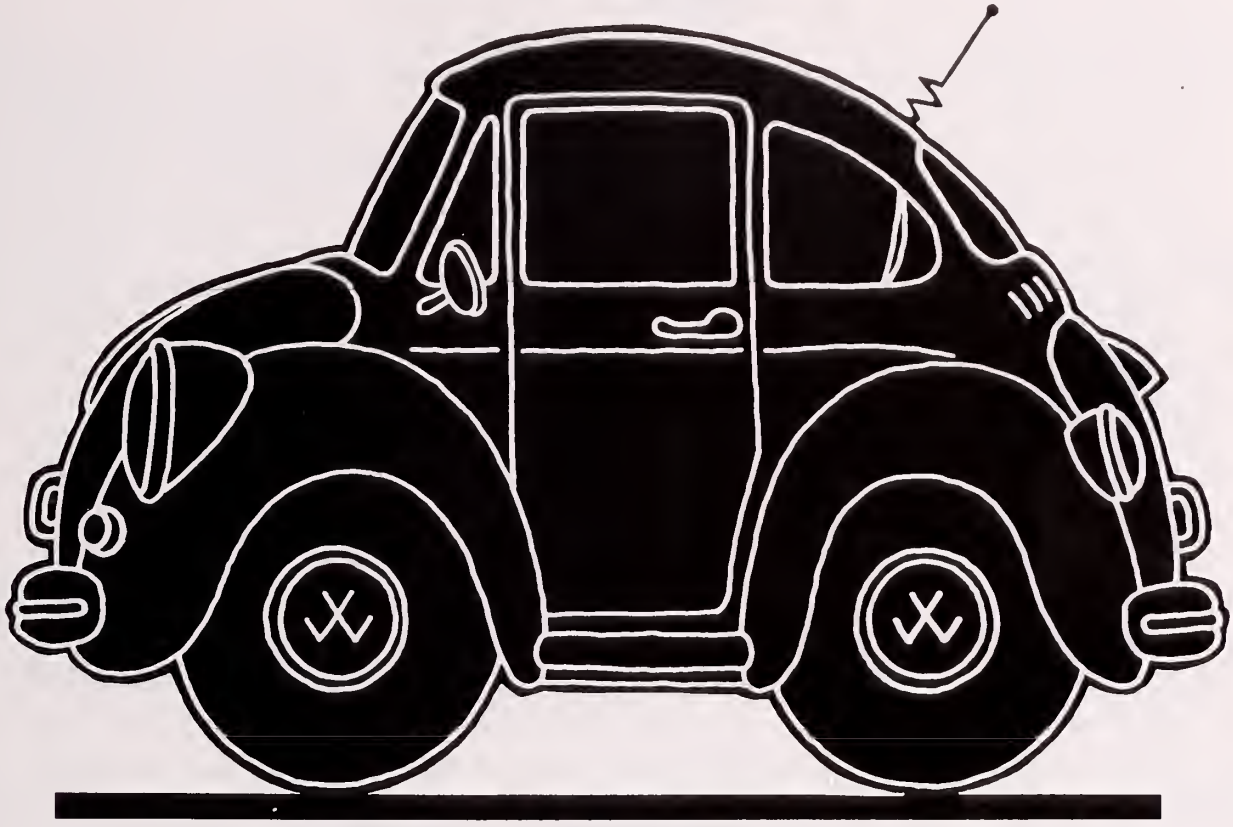
See complete Professional Use Information before prescribing.

0642T5

References: 1. *Physicians' Desk Reference®*, ed 39. Oradell, NJ, Medical Economics Company Inc, 1985. 2. Cohn PF, Braunwald E. Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease: A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 3. Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. *Mod Med* 1982; 50(Sept):94-116. 4. Subramanian VB: Comparative evaluation of four calcium antagonists and propranolol with placebo in patients with chronic stable angina. *Cardiovasc Rev Rep* 1984; 5:91-104. 5. Schroeder JS, Feldman RL, Giles TD, et al: Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 1982; 72:227-231. 6. Weiner DA, McCabe CH, Cutler SS, et al. The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. *Clin Cardiol* 1985; 7:648-653. 7. Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec):150-159.

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137



Finally, A Phone For The Economy Car.

It's the BellSouth Mobility car phone. And it's now the most affordable and reliable phone on wheels–no matter what car you drive. That's why BellSouth Mobility has put more phones in more cars than anyone in the Southeast.

Our car phone is just as easy to use as the phone in your home. In fact, it's really like having another extension–only this one goes 55 miles per hour. So call BellSouth Mobility for full details today at **1-800-351-3355.** Because all the way from Jupiter to Florida City, we really are the phone company for your car.



The Phone Company For Your Car.℠

BellSouth Mobility

A *BELL*SOUTH Company

©1986 BellSouth Mobility

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JUNE 1986, Vol. 73, No. 6

CONTENTS

SCIENTIFIC ARTICLES

R.R. Vijayanagar, M.D., Diego A. Bognolo, M.D., Paul F. Eckstein, M.D., Diane L. Jeffery, M.D., Eric E. Harrison, M.D., Edgar H. Willard III, M.D., and S.K. Musunuru, M.D. **447** Cardiac surgery in high risk octogenarians — is it feasible?

Guy Benrubi, M.D., Robert C. Nuss, M.D., and John Ameen, M.D. **450** Comparison of pre-operative endometrial sampling with operative specimen histology

Jonni H. Klapper, M.D. and James M. Sherman, M.D. **454** Nontypable Hemophilus influenzae infection of a congenital bronchogenic cyst

SPECIAL ARTICLES

Richard J. Feinstein, M.D. **459** Underground medicine: the widening problem of unlicensed physicians in the United States

COVER

This month's cover of *The Journal* is a drawing by James B. Upright, a Jacksonville artist. It depicts the article in this issue entitled "Cardiac surgery in high risk octogenarians — is it feasible?"

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.* [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc., are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Florida Medical Association, Inc.

DEPARTMENTS

439 President's Page
A step in the right direction
Luis M. Perez, M.D.

441 Editorials
The shame of nursing homes
R.G. Lacsamana, M.D.
Some thoughts on graduation
Henry L. Harrell Jr., M.D.

465 Medical Economics
Peer review organizations: what is the record so far?
Jacques R. Caldwell, M.D.

473 Notes & News

474 Dean's Message

475 Encores!

479 Correction

483 FMA Auxiliary
The march on Tallahassee
Mrs. James (Rita) Seymore

486 Meetings

490 Classified Advertising

494 Index to Advertisers

494 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

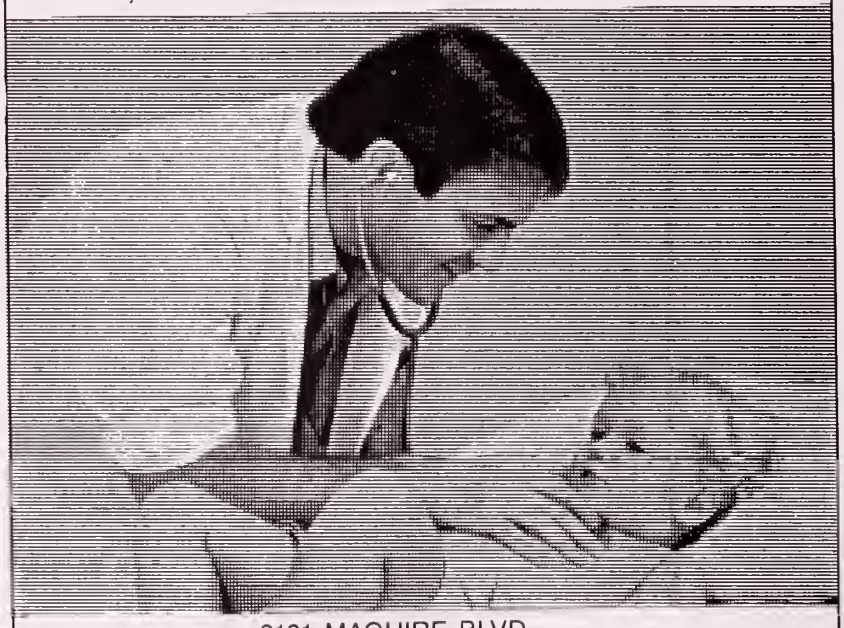
Consulting Editorial Staff:
Karl Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.

PHYSICIANS, WE SCHEDULE OUR TIME TO FIT YOUR TIME.

We're very flexible in the Army Reserve about time. We take into account your practice, your time and availability.

We're not flexible about the quality of medicine. We demand much of ourselves and of every member of our medical team.

If you'd like to learn more about the medical opportunities in a nearby Army Reserve unit, call your Army Medical Personnel Counselor:



3101 MAGUIRE BLVD.
ESSEX BLD., SUITE 166
ORLANDO, FL 32803
CALL COLLECT: (305) 896-0780

ARMY RESERVE. BE ALL YOU CAN BE.

A step in the right direction



The Legislative Session has completed another year, and we have achieved the best victory so far in our battle for liability reform for our profession and the people of our state.

With the help of the Florida Coalition for Liability Reform and the strength of the 700,000 people it represents, we have been able for the first time to make the legislators aware that a cap on damages was necessary and modifications of the doctrine of joint and several liability were needed. In addition, future economic losses as to amounts exceeding a $250,000 threshold will be structured over several years. Itemized verdicts will now be required for damage awards in civil actions and the judge will be required to reduce the judgement by the amount of contributions to the claimant from collateral sources; this provision applies if a subrogation right exists. The bill provides protections against frivolous law suits through an offer of judgement demand for judgement rule, and if punitive damages are asserted, imposes pleading requirements and limitations on them equal to three times the amount of compensatory damages, unless the judge is presented with clear and convincing evidence that the jury award above that amount is not excessive. Forty percent of the punitive damage award goes to the plaintiff and 60% of the award goes to the Public Medical Assistance Trust Fund (in wrongful death/personal injury cases).

The fact that we have been able to establish an absolute $450,000 cap on general damages, in spite of the opposition by the trial bar and the leadership of both houses, is indeed a great feather in our cap.

The harsh mandatory insurance provision passed by the Legislature in 1985 has been substantially modified. You will recall that the medical malpractice law enacted by the Legislature in 1985 contained a provision that requires all physicians to maintain professional liability insurance as a condition of licensure effective January 1, 1987. During the 1986 Session, the FMA supported total repeal of the mandatory provision. The result of this effort was to bring about substantial modifications to the law that will allow physicians who chose to do so to remain uninsured. The modified law provides that an uninsured physician must agree to make arrangements to satisfy a judgement within his or her financial capabilities or face disciplinary action by the State Board of Medical Examiners. This change was a major triumph.

It is true that we did not achieve the levels that we set as our goals. It is also true that we know you never get from the legislators all you ask. We have crossed a psychological barrier that had prevented the adoption of any cap on damages and any change to the doctrine of joint and several liability. The crossing of

this barrier is a major triumph for organized medicine in this state.

We have achieved this victory because of the unity we demonstrated, not only on April 21, when we went to Tallahassee as a part of the Coalition, but in all the weeks that followed when more physicians than ever visited the Capitol and talked with their legislators in a very effective and forceful manner.

Members of the Coalition also wrote an unprecedented number of letters and visited their delegations making the legislators realize that our petitions were not based on a doctors versus lawyers issue, but the people versus the system. The system has been distorted and does not fulfill the functions for which it was created. Fairness of the law practically has been lost and the whim of the jurors moved more by sympathy and pity rather than by facts has replaced it. The changes adopted this session will, we hope, begin to return reason and justice to the civil liability system.

The work is not over; we have to continue our efforts and through the cooperation of the Coalition become an effective force in the November elections. We have a sacred duty to protect our friends in the Legislature and to do everything possible to defeat our opposition.

More about this in the near future.



The shame of nursing homes

The recent revelations by the Senate Special Committee on Aging about substandard conditions in many nursing homes across the country were hardly a surprise to the medical community. Many physicians who for years have been visiting their patients in nursing homes knew that something was remiss about how many of these facilities are being run. What came as a surprise to physicians is the large number involved: more than one third of the nations's skilled nursing homes were not complying with critical health and safety standards. The litany of charges against these nursing homes is also appalling: lack of 24-hour nursing care, abuses of patients, filthy and squalid conditions, and failure to provide patients with adequate nutrition. So outraged was Senator John Heinz, the chairman of the Senate committee, that he termed many of these nursing homes as "19th century asylums" rather than modern health care facilities.

Senator Heinz as well as physicians and the public have every reason to be indignant about the situation. Many elderly patients in nursing homes are feeble and helpless, unable to complain many times about the type of treatment that they receive. To think that hundreds of thousands of elderly Americans are spending their last years victimized by the indignities and inhumane treatment offered in many nursing homes is abominable. There is ample evidence to suggest that many nursing homes have become nothing more than convenient dumping places for those whom we no longer find any use for. Such widespread public perception is a cruel indictment of the way we treat our elderly, and it should nag our collective conscience that we have done little to dispel it.

But apart from the sullied image to our civility that the recent Senate report carries, there is also the problem of economics. Nursing home care can be quite expensive, both to families that can afford it and to the government which subsidizes the expenses of those unable to afford it. The steadily increasing number of Americans 65 years old or over, many of whom may require nursing home care in the future, will boost national expenses even more. Even now, programs started by the government for Medicare beneficiaries are aimed at early discharges of hospitalized patients and wider use of outpatient facilities like nursing homes. But how are we to reconcile future staggering expenses with the sordid report card of our nursing homes?

Both the government and the nursing home owners are to blame for bringing about the current problems unearthed by Senator Heinz and his committee. HHS and HCFA have been derelict in enforcing established standards and meting out sanctions to those that have been grossly violating rules and regulations established by the federal and state governments. Only 200 of the 3,016 nursing homes cited for violating these standards in 1984 lost Medicare and Medicaid funding in 1985. It is the classic story of the cat and the mouse, and the mouse is winning the game.

The increasing commercialization of health care where nursing homes have become a booming business partly accounts for the poor performance of nursing homes in taking care of the elderly. Lest anyone doubt this, one favorite darling of Wall Street is a company out of Pasadena which owned, as early as 1982, more than 700 nursing homes across the country. The profit motive, for individual owners and big companies alike, can adversely affect the quality of care given to patients. Most of us who go to nursing homes regularly are familiar with the chronic shortage of help and qualified nursing personnel, the resultant lack of care to patients, the complaints from families,

the overcrowded and sometimes squalid quarters, and the uncaring atmosphere in many of these facilities. The recurring nightmare of patients going to the hospital repeatedly for dehydration, malnutrition, and bedsores bespeaks of the shortcomings plaguing the existing system.

Nursing homes are a unique American phenomenon and will continue to fulfill a role for American society in the future. In contrast, nursing homes are absent or almost unheard of in Asia and many other parts of the civilized world. Cultural differences account for this phenomenon. In the Orient, for example, where family ties are very close, the elderly are taken care of by family members. While this is not to say that Americans do not care for their elderly equally well, there is not the same close-knit interdependence among generations of a family as is found elsewhere. The demands of a highly industrialized society like ours, where most adult children are at work, also compel families to send their elders to nursing homes. In essence, nursing homes are here to stay, but it is important at the same time to ensure that patients can live in them in comfort and dignity and with reasonable asssurance that they will get decent nursing care.

Federal and state authorities must move quickly to stem the problems and to prevent the current situation from getting worse. The Department of Health and Human Services, which oversees nursing homes that receive federal funds, should conduct more frequent inspections, enforce standards more rigidly, publicize the names of those facilities that fail to meet standards, and revoke the licenses of those that provide grossly substandard nursing care. The HCFA, for its part, should withhold funds from those that are chronically not in compliance with standards. Both physicians and the public will thus be assured that only those facilities that can meet exacting standards ought to be in the business. The commitment to provide decent care for our elderly should be a primary obligation for a society that ostensibly values its human resources.

R.G. Lacsamana, M.D.
Editor

Some thoughts on graduation

June is a month of graduations. It is a time of celebration of the completion of a stage in the formal education of our young people. It is also a time to look ahead to their future — a time of "Commencement."

We physicians have come through many such graduation/commencements and cannot help but look upon those who are following us with very mixed feelings. In recent years there has been an increasing awareness among practicing physicians that our profession is in the the throes of turbulent change. The idealized physician that many of us sought to emulate as we committed our lives to medicine years ago may have never really existed, but even the myth is vanishing now. Dr. Marcus Welby, who could spend days on end with a single case and always knew a miraculous cure for every disease, seems less realistic than Yoda, the Jedi Master today. We have come to realize that the more miraculous our tools of diagnosis and treatment become, the more complex and confusing the maintenance and restoration of health seem to be. The public has demanded more understanding of what we are doing, and having received more information, is impressed by our limitations and increasingly distrusts us. The awe which once was held for the family physician has been shifted to the "nutritionist" and diet quack. At the same time, there is intense pressure to lower the cost of medical care. Physicians at all levels are struggling with how this can be done, but for the most part the changes taking place are being done to us, not by us. No one can know what medicine will be like in five, 10, or 20 years in this country.

For those who are graduating from medical schools this month, the die is cast. It is too late to go back. They will be coming out of postgraduate residencies and fellowships directly into the middle of this boiling cauldron of change. It is not a position to be envied, but much of the future of American medicine may depend on them. Most of them decided to be doctors out of a desire to serve others and to do something fulfilling and satisfying with their lives. They must join others of us already in practice in fighting to maintain those goals. Regardless of what they will hear repeatedly, they are not entering an industry or going into a business. They are setting out on a lifetime of service to the individuals who will be their patients. In the process, they will probably make a good living, but to whatever extent they emphasize business rather than service they will have cheated themselves, their patients, and the profession. Whether they are in solo fee-for-service practice or in a huge multispecialty prepaid system, their duty must be to their patient and their greatest reward will be from serving him well. We must not forget that, no matter what system or combination of systems finally prevail as the most just and efficient way to deliver health care in this nation.

The graduates of premed courses who are soon to enter medical school are also relatively committed in their course. There is more time to direct their education away from medical practice to such things as basic science research, but most of them will persist toward practice. They will have a four year advantage of seeing where medicine is headed, but it is highly unlikely that many issues will be settled that

quickly. We would encourage them to prepare themselves diligently, first by acquiring the scientific knowledge they will need to be good doctors, but then also by learning the moral and ethical tenets of our profession and preparing to maintain them in their own future work.

And finally there are the high school graduates who have made that initial decision to set their sights toward medicine as a career. It is a popular half-joke among physicians these days to respond to the parent of such a child with: "Can't you talk him out of it?" There are, unfortunately, a few among us who have grown so embittered as to wish they had never gone into medicine in the first place. This is, however, only a small minority. Most physicians are insecure about the future, disappointed with the pressures and confusion of the the present, but still very satisfied with their own choice of professions. The gratitude of a patient who has been saved from disaster, the intellectual satisfaction of working out a confusing diagnosis and seeing the proper treatment work, or the emotional satisfaction of being able to help others through very difficult times in their lives are precious to us. It would be wonderful if all young people could go into a life's work that offered such rewards. Certainly those who make it into medicine can look forward to many opportunities for personal fulfillment. Hopefully much of the uncertainty and distrust in medicine today will have been resolved when they are ready to join us.

Henry L. Harrell Jr., M.D.
Ocala



Health Care At Its Best: Air Force Medicine

Air Force medicine is one of our best benefits, and, with your help, we'll keep it that way. The Air Force needs physicians such as you to become members of our health care team.

Most administrative responsibilities are in the hands of others, giving our physicians the time to give their full attention to the patients' needs. Our hospitals are staffed with dedicated, competent professionals.

You'll find you will have time for your family, and to keep abreast of the latest methods and technologies that you don't have time for now. We also offer unlimited professional development and financial security.

If you're considering a change, consider Air Force medicine. To find out more about Air Force medicine, contact your nearest Air Force recruiter. Experience health care at its best.

Contact: Medical Recruiter, 305/494-2728 or 305/494-2730. An equal opportunity employer.

AIR FORCE

A great way of life.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5mg Buccal/10mg Oral/25mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10mg

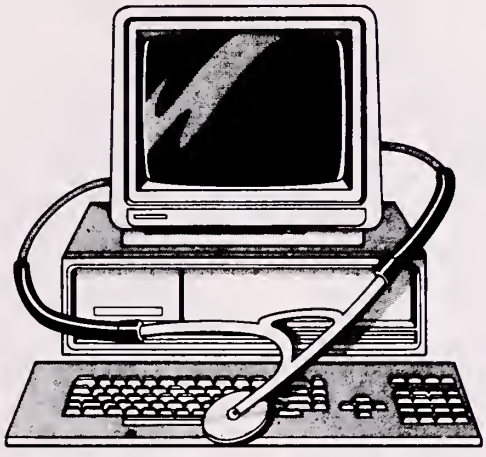




MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

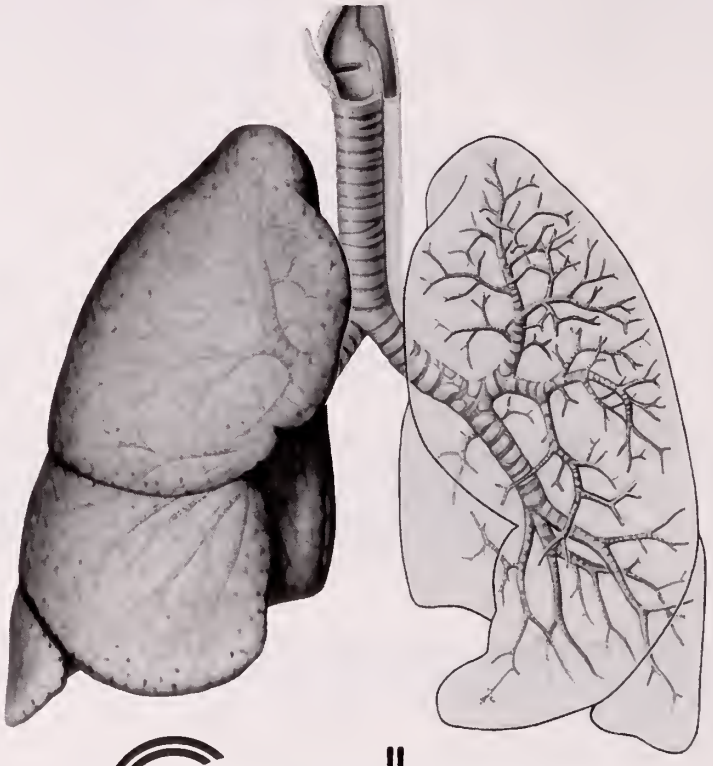
Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae*, *H influenzae*, *Streptococcus pneumoniae*, *Streptococcus pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

© 1986, ELI LILLY AND COMPANY [060485LR]

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

600332

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
JUNE 1986, Vol. 73, No. 6

Cardiac surgery in high risk octogenarians — is it feasible?

R.R. Vijayanagar, M.D., Diego A. Bognolo, M.D., Paul F. Eckstein, M.D., Diane L. Jeffery, M.D., Eric E. Harrison, M.D., Edgar H. Willard III, M.D., and S.K. Musunuru, M.D.

ABSTRACT: With life expectancy for an average American on the rise, the medical profession is increasingly confronted with major cardiovascular problems in the very elderly. To find a rational approach to this growing problem, the following clinical study was undertaken. Forty patients aged 80 to 86 years (m = 81.5) with functional class IV symptomatology underwent cardiac surgery between January 1978 and February 1983. The group consisted of 25 males and 15 females. Operative procedures were isolated coronary artery bypass (CAB) in 19, CAB and axillo-bifemoral in one, aortic valve replacement (AVR) in 11, isolated MVR in eight and closure of acquired ventricular septal defect (VSD) in one. Six patients with valve replacement also had concomitant CAB. Operative mortality in this high risk group was 22%. The data are suggestive that cardiac surgery in this high risk group of octogenarians is feasible, and that careful analysis of collective preoperative risk factors (renal failure (RF), ejection fraction (EF), emergent procedures and treated hypertension (TH)) can help to reduce the mortality.

The Authors
R.R. VIJAYANAGAR, M.D.
DIEGO A BOGNOLO, M.D.
PAUL F. ECKSTEIN, M.D.
DIANE L. JEFFERY, M.D.
ERIC E. HARRISON, M.D.
EDGAR H. WILLARD III, M.D.
S.K. MUSUNURU, M.D.
Drs. Vijayanagar, Bognolo, Esckstein, Jeffery, and Harrison are with the Tampa Heart Center, Tampa General Hospital, University of South Florida College of Medicine, Dr. Willard is with the Bond Clinic, Winter Haven, and Dr. Musunuru is with the Bayonet Point Regional Medical Center, Hudson.

Cardiac surgery for the geriatric age group has become established.[1-16] Cardiovascular pathology in the very elderly has been documented by necroscopy findings.[1] There are numerous reports of successful surgical procedures in patients in the sixth and seventh decades of life, with surgical mortality ranging from 1 to 25%.[1-16] What has not yet been clearly addressed is the issue of major cardiovascular problems in the very elderly (ninth decade) and very sick (Class IV) patients. This particular clinical dilemma is much more prevalent in our state, because of the increasing number of elderly retirees settling in the Sunshine State. To find a rational approach to this growing problem the following clinical study was undertaken.

Patient and methods • Forty patients 80 to 86 years of age (mean 81.5) with functional Class IV symptomatology underwent cardiac surgery between January 1978 and February 1983. The group consisted of 25 males and 15 females. Pertinent demographic and clinical data are given in Table 1. One patient with severe aortic stenosis was too ill for cardiac catheterization. Therefore, 39 patients had cardiac catheterization which documented mitral valve disease in eight, aortic valve disease in 11, coronary artery disease in 32 and acquired ventricular septal defect (VSD) in one (Table 2). Prior to surgery, the following risk factors were documented: mental confusion, hypertension, history of stroke, diabetes, renal failure and ejection fraction < 50% (Table 3). Univariate analyses using standard t tests and Chi Square methods were used for these factors. Of the 40 patients requiring cardiac surgery, five were emergent surgical procedures. They consisted of coronary artery bypass grafting in two, coronary artery bypass grafting and axillo-bifemoral

Table 1. — Demographic and Clinical Data

	Clinical Data	Patients
AGE	Youngest	80
	Oldest	86
	Mean	81.5
SEX	Males	25
	Females	15
CHEST X-RAY	Normal	17
	Cardiomegaly	23
ELECTRO-CARDIOGRAM	Old MI	6
	L.V.H.	10
	Other	24
RHYTHM	Sinus	33
	Atrial fibrillation	5
	Paced	2
FUNCTIONAL CLASS	All patients in class IV	

MI: Myocardial Infarction
L.V.H.: Left Ventricular Hypertrophy

bypass in one, mitral valve replacement in one and closure of acute post myocardial VSD in one (Table 4).

Results and follow-up • There were nine operative or hospital deaths for a mortality of 22%. Seven deaths were related to cardiac failure and two were non-cardiac. One patient died of ruptured duodenal ulcer and another patient had acute hemorrhagic pancreatitis following isolated coronary bypass surgery. Five of the nine deaths occurred following emergent cardiac surgical procedures. Details of surgical procedures related to mortality are given in Table 5. Twenty-three patients had a total of 31 complications. There was no correlation between complications and pre-operative risk factors except for pre-operative mental confusion and renal failure (Table 6). Significant predictors of operative mortality included renal

Table 2. — Diagnosis by Cardiac Catheterization in 39 Patients

Diagnosis	Patients
Mitral stenosis	1
Mitral regurgitation	5
Mixed mitral lesion	2
Aortic stenosis	6
Aortic insufficiency	3
Mixed aortic lesion	2
Coronary disease	32
Acquired VSD	1

VSD: Ventricular septal defect

Table 3. — Possible Risk Factors

Risk Factors	Patients
1. Mental confusion	6
2. Hypertension	20
3. History of stroke	3
4. Diabetes	9
5. Renal failure	9
6. EF < 50%	11

EF: Ejection fraction

failure, decreased ejection fraction (< 50%), and emergent and combined cardiac procedures ($p < 0.05$). Only one of the nine patients who died in the hospital had none of the above mentioned risk factors. In addition, correlations were found between mortality and mental confusion ($p < .08$) and treated hypertension ($p < .05$). There have been three late deaths (average = four months). One patient died during sleep, one patient had massive pulmonary embolism and one death was due to an apparent cardiac arrest. The average follow-up for the remaining survivors has been 8.5 months ± 6.6. These patients have been reported to be healthy and enjoying active retirement (Table 7).

Table 4. — Operative Procedures

Coronary artery bypass only	19
Coronary bypass and axillo-bifemoral bypass	1
Mitral valve replacement	8*
Aortic valve replacement	11*
Acute VSD repair	1

*Six had coronary bypass

Table 5. — Results

Operative deaths	- 9	= 22%
Cardiac	- 7	= Low cardiac output
Non-cardiac	- 2	= Pancreatitis and ruptured duodenal ulcer

Type of Surgery and Mortality

	Patients
Coronary artery bypass (CABG)	3
Coronary bypass and ax-bifemoral	1
Aortic valve replacement (AVR)	1
AVR & CABG	1
Mitral valve replacement	1
MVR & CABG	1
Acquired VSD	1
Total	9

Table 6. — Postoperative Complications

Low cardiac output	6
2° and 3° HB	4
Ventricular arrhythmia	4
Atrial arrhythmia	7
Renal failure	8
Mental confusion	5
Stroke	1
Postoperative bleeding	5
GI bleeding	1
CHF	1
Pneumothorax	1
Sepsis	1
Hematuria	1

HB: Heart block
GI: Gastrointestinal
CHF: Congestive heart failure

Discussion • When a physician is confronted with major cardiovascular problems in the very elderly and very sick, philosophical, socioeconomic, medical and surgical judgements are critically tested. Philosophically no particualr value can be placed on any given life of any individual at any age. Chronologic age may be to a large extent unrelated to physiologic or mental age. For example, an 85-year-old female patient of ours was admitted with acute mitral regurgitation and single vessel coronary artery disease. She was very alert, intelligent and had cared for herself prior to this acute illness. This patient is now 90 years old, post-mitral valve replacement, and leads a healthy, independent, and very gratifying life. Rational and logical judgement including evaluation of various risk factors and a thorough discussion with the patient and family can help in managing these critically ill elderly patients.

If a patient has isolated aortic stenosis or has coronary artery disease with good left ventricular function, excellent postoperative results and postoperative survival can be anticipated. Such results have been documented by us and in several similar reports.[1-16] Our mortality rate of 22% seems to be high, but all of our patients were in Class IV status and perhaps we should not have performed the emergency operations in five patients listed earlier. One of the emergency operations performed was closure of an acute VSD. If these five patients are excluded, the mortality rate is justifiable for the remainder of our patients. Operative results even for valve replacement with concomittant coronary artery bypass grafting after the sixth and seventh decade of life generally have improved.[2,3,5,13,14] While such excellent reports are available, it is an indisputable fact that mortality and morbidity rates are higher for elderly patients, especially after the seventh decade of life.[2-16] It is also true that the mortality rates for mitral valve surgery are higher than for other cardiac procedures, namely coronary artery bypass grafting and isolated aortic valve replacement.[3,5,12,14] Jamieson et al, analyzing cardiac valve replacement in the elderly, reported a 4.7% mortality for aortic valve replacement and 11.4% for mitral valve replacement. Multiple valve replacements had a mortality of 37.5%.[12] Gersh et al, reporting a coronary artery surgery study indicate that mortality rates were directly proportional to increasing age.[6] Mortality was 4.6% for patients between 65-69 years of age and 9.5% for patients over 75.[6] It can be reasonably concluded from our experience as well as from an analysis of the literature that morbidity and mortality are higher in the very elderly. Very careful evaluation of an individual patient as a whole, rather than isolating a disease process, particularly in the very elderly and the very ill, will guide us in the just management of these patients.

Table 7. — Follow-Up

Survivors	31
Average follow-up	8.5 months ± 6.6
Late deaths	3 (Average: 4 months)

Patients healthy and enjoying active retirement: 28

References

1. Waller, B.F and Roberts, W.C.: Cardiovascular Disease in the Very Elderly. Analysis of 40 Necropsy Patients Aged 90 Years or Over, Am. J. Cardiol. 51:403-421, 1983.
2. Djokovic, J.L. and Hedly-White, J.: Prediction of Outcome of Surgery and Anesthesia in Patients over 80, JAMA 242:2301-2396, 1979.
3. Stephenson, L.W.; MacVaugh, H., and Edmunds, L.H.: Surgery Using Cardiopulmonary Bypass in the Elderly, Circulation 58:250-253, 1978.
4. Berman, N.D.; David, T.E.; Lipton, I.H., and Lenkei, S.C.: Surgical Procedures Involving Cardiopulmonary Bypass in Patients Aged 70 or Older, J. Am. Geria. So., 28:29-32, 1980.
5. Smith, J.M.; Lindsay, W.G.; Lillehei, R.C., and Nicoloff, D.M.: Cardiac Surgery in Geriatric Patients. Surgery 80:443-447, 1976.
6. Gersh, B.J.; Kronmal, R.A.; Frye, R.L.; Schaff, H.V.; Ryan, T.J.; Gosselin, A.J.; Kaiser, G.C.; Killip, T., and Participants in the Coronary Artery Surgery Study: Coronary Arteriography and Coronary Artery Bypass Surgery: Morbidity and Mortality in Patients Ages 65 Years or Older, Circulation 67:483-491, 1983.
7. Berry, B.E.; Acree, P.W.; Davis, S.J.; Sheely, C.H., and Cavin, S.: Coronary Artery Bypass Operation in Septuagenarians. So. Thorac. Surgeons 31:310-313, 1980.
8. Knapp, W.S.; Douglas, J.S.; Carver, J.M.; Jones, E.L.; King, S.B.; Bone, D.K.; Bradford, J.M., and Hatcher, C.R.: Efficacy of Coronary Artery Bypass Grafting in Elderly Patients With Coronary Artery Disease, Am. J. Cardio. 47:923-930, 1981.
9. Gann, D.; Colin, C.; Hildner, F.J.; Samet, P.; Yahr, W.Z., and Greenberg, J.J.: Coronary Artery Bypass Surgery in Patients Seventy Years of Age and Older, J. Thorac. Cardio. Surg. 73:237-240, 1977.
10. Meyer, J.; Wukasch, D.C.; Seybold-Epting, W., Charello, L.; Reul G.J.; Sandiford, F.M.; Hallman, G.L., Cooley, D.A.: Coronary Artery Bypass in Patients Over 70 Years of Age: Indications and Results, Am. J. Cardio. 36:342-345, 1975.
11. Alam, S.E.; Hutchinson, J.E., and Schwartz, M.J.: Replacing the Aortic Valve During the Ninth Decade of Life, Geriatrics 100-101, 1977.
12. Jamieson, W.R.E.; Dooner, J.; Munro, A.I.; Janusz, M.T.; Burgess, J.J.; Miyagishima, R.R.; Gererin, A.N., and Allen, P.: Cardiac Valve Replacement in the Elderly: A Review of 320 Consecutive Cases, Circulation (Suppl. II) 64:II-177 — II-188, 1981.
13. Carlson, R.G.; Shafer, R.B.; Eliot, R.S.; Sellers, R.D., and Lillehei, C.W.: Results of Cardiac Surgery in 273 Older Patients, Geriatrics 173-183, 1967.
14. Bessone, L.N.; Pupello, D.F.; Blank, R.H.; Harrison, E.E., and Sbar, S.: Valve Replacement in Patients Over 70 Years, Ann. Thora. Surg. 24:417-421, 1977.
15. Habler, B.A.; Wright, J.O.; Wright, C.B.; Ehrenhaft, J.O.; Doty, D.B., and Rossi, N.P.: Coronary Artery Bypass Surgery in the Elderly, Archives of Surg. 118:402-404, 1983.
16. Hochberg, M.S.; Levine, F.H.; Daggett, W.M.; Akins, C.W.; Austen, G.W., Buckley, J.M.: Isolated Coronary Artery Bypass Grafting in Patients 70 Years of Age and Older, Jour. of Thor. and C.V. Surg. 84:219-223, 1982.

• Dr. Vijayanagar, One Davis Blvd., Suite 502, Tampa 33606.

Comparison of pre-operative endometrial sampling with operative specimen histology

Guy Benrubi, M.D., Robert C. Nuss, M.D., and John Ameen, M.D.

ABSTRACT: Four quadrant endometrial biopsy has been found to be a reliable method of assessment of endometrial pathology. It is currently used as a diagnostic tool in vaginal bleeding disorders, and also as a screening modality prior to elective hysterectomy, to rule out malignant disease necessitating a more extensive procedure.

One-hundred-eighteen (118) patients who had elective hysterectomy at University Hospital of Jacksonville, Florida between March, 1984 and January, 1985 had pre-operative endometrial biopsies. In 110 patients the histology of the biopsy correlated exactly with that found in the operative specimen for an overall accuracy of 93.2%. However, the sensitivity of endometrial biopsy for diagnosis of pre-invasive and invasive endometrial disease was inversely related to the age of the patient.

All the endometrial biopsies which were incorrect, as compared to the final specimen, underdiagnosed the underlying problem.

The Authors
GUY BENRUBI, M.D.
ROBERT C. NUSS, M.D.
JOHN AMEEN, M.D.
Dr. Benrubi is Assistant Professor, Division of Gynecologic Oncology, Dr. Nuss is Chief, Division of Gynecologic Oncology, and Dr. Ameen is Resident at University Hospital of Jacksonville.

According to recent epidemiologic estimates, the average life expectancy of women is steadily increasing. Women in the United States live an average of 30 years past the average age of menopause.[1] In recent years, a significant increase (25 to 50%) in the prevalence of endometrial carcinoma has been observed in North America over that reported ten years ago. This increase has been primarily attributed to life span past the menopause, exogenous estrogen therapy, and the use of more refined criteria for diagnosing early adenocarcinoma.[2]

Furthermore, several studies have reported that up to 25% of all cancers of the endometrium occur in pre-menopausal females.[3,4] Also of note is that 60 to 85% of women who develop endometrial cancer have not been exposed to exogenous estrogens.[5] Therefore, it is obvious that all women with abnormal bleeding or watery discharge, at any age, whether on hormone therapy or not, should be closely observed and their endometrium sampled.

Endometrial curettage is the operation most frequently performed on women throughout the world. In view of present hospital costs, physicians have diligently searched for ways to sample the endometrium as an outpatient without sacrificing the quality and accuracy of the sample. The methods investigated have included aspiration or aspiration following lavage, rotating a small brush in the endometrial cavity, and jet washing of the endometrial cavity for removal of material for cytologic study. As in other cytologic studies, negative findings are inconclusive, and suspicious or positive results must be confirmed by examination of tissue removed by subsequent curettage.[6]

In our institution, over the past several years, patients of all ages have had pre-operative endometrial sampling before hysterectomy, regardless of pre-

operative diagnosis. In this analysis, all pre-operative endometrial biopsies between March, 1984 and January, 1985 are compared with operative specimens to evaluate sensitivity and specificity in detecting malignant and pre-malignant endometrial lesions in different age groups.

Materials and methods ● The study group was composed of 118 patients attending the University Hospital Gynecology Clinics. The age range was 20 to 78 years of age. Presenting complaints or pre-operative diagnoses included abnormal uterine bleeding (84 patients), pelvic mass including leiomyoma (16 patients), chronic pelvic pain (10 patients), tubo-ovarian abscess (1 patient) and cervical intraepithelial neoplasia (7 patients). The group of patients with abnormal bleeding included 14 post-menopausal and 8 peri-menopausal patients.

After the decision was made to perform hysterectomy, pre-operative endometrial biopsies were performed to screen for intrauterine malignant or pre-malignant lesions. The Novak suction curette was used without anesthesia, and biopsies were done by residents in the Department of Obstetrics and Gynecology.

Endometrial sampling was preceded by bimanual pelvic examination to determine uterine size, shape, position, and mobility. The cervix was then cleaned with povidone-iodine 1% solution. A single-tooth tenaculum was applied to the anterior lip of the cervix and gentle traction applies to straighten the uterine axis. When endocervical curettage was indicated, it was performed with a Kevorkian curette. The uterus was then sounded to determine its depth. The Novak curette was inserted past the isthmus, and pressure applied so that the serrated edges at the opening scraped the endometrial surface upon withdrawal. A syringe was attached to the curette, and constant suction used to increase the amount of tissue obtained. Four-quadrant sampling was performed, and the specimen immediately placed in 10% formalin and submitted to pathology.

All patients tolerated the procedure well, with minimal discomfort, and no perforations or excessive bleeding was noted in any patients.

Hysterectomy was performed in all patients within four months, and pathology reports of pre-operative and operative specimens were compared.

Results ● The entire group of 118 patients underwent hysterectomy which revealed seven to have adenocarcinoma, two to have atypical adenomatous hyperplasia, and the remaining 109 to have non-neoplastic findings. Included in the benign diagnoses were cystic atrophy, acute and chronic endometritis, and benign polyp.

The mean age of women with endometrial adenocarcinoma was 62, and presenting symptoms were post-menopausal bleeding in all seven cases. Pre-operative endometrial biopsies correctly identified the lesions in four of these seven patients, for an accuracy of 57%. Endometrial biopsies failed to identify atypia in both patients with atypical hyperplasia.

The endometrial biopsies were compared with hysterectomy specimens and results broken into age groups. In the group of patients less than 45 years of age, there was 100% accuracy in 76 with pre-operative biopsies. The only malignant or pre-malignant lesion identified in this group was one case of gestational trophoblastic neoplasia in a 23-year-old.

In the 46 to 50-year-old group, 15 of 16 biopsies agreed with post-operative findings for a 94% accuracy rate. The endometrial biopsy failed to pick up atypia in one 46-year-old with a pre-operative diagnosis of adenomatous hyperplasia.

In the 51 to 60-year-old group, 13 of 15 biopsies were confirmed by operative specimens, for an 86% accuracy rate. One case of adenocarcinoma was identified pre-operatively as adenomatous hyperplasia. The other "failure" in this group was identification of a focus of squamous cell cancer in the pre-operative endometrial biopsy of a woman with cervical cancer. There were no endometrial findings in the hysterectomy specimen.

In the 61 to 70-year-old group, four of nine endometrial biopsy findings were confirmed by hysterectomy, for a 44% accuracy rate. One case of cervical cancer showed squamous carcinoma on endometrial biopsy which was not subsequently found at hysterectomy. In one patient, pre-operative focal mild adenmatous and cystic hyperplasia was not found in the operative specimen. Insufficient tissue on endometrial biopsy failed to diagnose advanced adenomatous hyperplasia with atypia in one patient, and adenocarcinoma in another. Well-differentiated adenocarcinoma was found in one patient with a pre-operative diagnosis of adenomatous hyperplasia with marked atpyia.

There were two patients older than 70, and both had benign endometrial biopsies confirmed by hysterectomy, for 100% accuracy in this very small group.

Results are presented in Tables 1 and 2.

Discussion ● This study encompasses an eleven month experience in a gynecology clinic setting at a teaching hospital using endometrial biopsy as a routine pre-operative screening technique. Biopsies were performed by attending staff and residents at all levels of training, thus eliminating inexperience as a prevalent factor in this study. There was no attempt to select those patients who had a D & C following the biopsy.

There were three false positive results or malignant and suspicious lesions. Two of these patients had cervical cancer diagnosed pre-operatively, and the

Table 1. — Correct Diagnosis as Compared to Age

Age	N	Number Correct	Percent Correct
<45	76	76	100
46-50	16	15	94
51-60	15	13	86.6
61-70	9	4	44
>70	2	2	100
Total	118	110	93.2

squamous carcinoma detected pre-operatively on endometrial biopsy may have actually been obtained in the endocervix, or possibly represented endometrial extension that was totally excised by the biopsy. The third case represented focal mild cystic and adenomatous hyperplasia which was apparently excised in toto at the time of endometrial biopsy. The other discrepancies between pre-operative and operative samples represented under-diagnoses. These cases were reviewed further.

A 62-year-old white female presented with post-menopausal bleeding. Her weight was 223 pounds, and she had no other significant past medical history. She had been on no estrogen replacement since menopause 13 years earlier. Endometrial biopsy was performed by a second year resident, and showed adenomatous hyperplasia with marked architectural atypia. Subsequent hysterectomy revealed well-differentiated adenocarcinoma with extension halfway through the myometrium. Endometrial polyp with atypical hyperplasia was also discovered.

A 65-year-old white female presented with third degree uterine prolapse. Her weight was 196 pounds, and she had a history of hypertension. She had received no estrogen replacement, and menopause had occurred 15 years ago. Endometrial biopsy was performed by a fourth year resident, and showed insufficient tissue for diagnosis. Operative specimen revealed advanced cystic hyperplasia with minimal atypia.

Table 2. — Discrepancies Between Biopsy and Operative Specimen

Biopsy	Operative Specimen	Number	Age
Insufficient tissue	Carcinoma	1	61
Insufficient tissue	Atypia	1	65
Hyperplasia	Carcinoma	1	59
Hyperplasia	Atypia	1	46
Hyperplasia	Benign	1	64
Atypia	Carcinoma	1	62
Carcinoma	Benign	2 (both had CA of cervix)	56,63

A 61-year-old black female presented with uterine prolapse and post-menopausal bleeding. Her weight was 183 pounds, and she had no other significant past history. She had received no post-menopausal estrogen replacement. Endometrial biopsy was performed by an attending physician and showed insufficient tissue for diagnosis. Hysterectomy specimen revealed well-differentiated adenocarcinoma.

A 59-year-old black female presented with post-menopausal bleeding. Her weight was 275 pounds, and she had a history of hypertension and diabetes. She had received no previous estrogen replacement. Biopsy was performed by a third year resident, and revealed adenomatous hyperplasia without atypia. Operative specimen showed well-differentiated adenocarcinoma.

A 46-year-old white female presented with peri-menopausal bleeding. She weighed 150 pounds, and had no other significant past medical history. She had received a short course of Provera in the past for her bleeding. Biopsy was performed by a first year resident, and showed adenomatous hyperplasia without atypia. Hysterectomy specimen revealed adenomatous hyperplasia with areas of atypia.

In this group, there were no patients on estrogen supplements. Four of the five patients presented with menopausal or post-menopausal bleeding. The average weight of these patients was 205 pounds, indicating the possible problems of obtaining adequate biopsies in obese women. Two patients had insufficient tissue for evaluation.

There were three patients in whom pre-operative endometrial biopsy failed to pick up endometrial cancers. In two of those the ultimate cancer was a well-differentiated tumor and these patients received total abdominal hysterectomy and bilateral salpingo-oopherectomy, therefore, the lack of pick up did not change the anticipated clinical course. The third patient did have a moderately well differentiated endometrial cancer with invasion to the inner two-thirds of the myometrium. This patient did not have nodal sampling at the time of her abdominal hysterectomy. This patient did receive post-operative pelvic radiation therapy. It is conceivable that the clinical management may have been different had the patient received intra-operative nodal sampling if the clinicians knew that the patient had endometrial cancer.

It is not surprising that the rate of endometrial cancer and atypia in the study group increased with age. However, it is significant that the accuracy of endometrial biopsy to evaluate severity of endometrial disease is inversely related to the age of the patient. Endometrial biopsy remains a useful procedure because it is a rapid office procedure and, if positive, obviates the need for hospitalization and D & C. However, its use must be accompanied by an under-

standing of its limitations. Whenever a non-diagnostic or suspicious result is obtained in cases of menopausal or post-menopausal bleeding, further endometrial sampling should be done, preferably by a D & C. An insufficient specimen should never be considered a negative biopsy. It should also be followed-up by D & C, especially if symptoms persist.

References

1. Hammond, C.B. and Maxson, W.S.: Current Status of Estrogen Therapy for the Menopause. Fertil. Steril. 37:5, 1982.
2. Jick, H.; Walker, A.M., and Rothman, K.J.: The Epidemic of Endometrial Cancer: A Commentary. AM. J. Pub. Health. 70:264, 1980.
3. Parsons, L. and Sommers, S.C.: Textbook of Gynecology, Philadelphia, 1962, W.B. Saunders Company, p. 1078.
4. Geisler, H.E.; Huber, C.P, and Rogers, S.: Carcinoma of the Endometrium in Premenopausal Women. Am. J. Obstet. Gynecol. 104:657, 1969.
5. Lucas, W.: The Epidemiology of Endometrial Cancer. Gynecology and Obstetrics, Vol. 4, Chapter 13, p. 1. Sciarra, John (ed.) Philadelphia, 1984, Harper and Row.
6. Baitlon, D. and Hadley, J.: Endometrial Biopsy. Am. J. Clinical Path. 63:9, 1975.

- Dr. Benrubi, Assistant Professor, Division of Gynecologic Oncology, University Hospital of Jacksonville, 655 West Eight Street, Jacksonville 32209.

Nontypable Hemophilus influenzae infection of a congenital bronchogenic cyst

Jonni H. Klapper, M.D. and James M. Sherman, M.D.

ABSTRACT: A 26-month-old child with a congenital bronchogenic cyst presented with a pulmonary abscess caused by nontypable Hemophilus influenzae (NTHI) resistant to ampicillin. Therapy with chloramphenicol and eventual surgical excision was successful. NTHI is an uncommon pathogen but may cause invasive disease in patients with anatomic abnormalities, chronic lung disease, or immunologic compromise and should be considered in infections not responding to usual therapy.

Previously normal patients with serious pulmonary infections caused by nontypable Hemophilus influenzae (NTHI) have rarely been reported. Infected patients usually have chronic respiratory diseases such as chronic bronchitis,[1] chronic obstructive lung disease,[2,3] bronchiectasis,[4] cystic fibrosis,[5] or are immunologically compromised.[1-3] Only a few pediatric patients with pneumonia or empyema caused by NTHI have been reported.[6-9] We wish to report a patient with a NTHI infection of a congenital lung cyst.

Case report • A 26-month-old female presented with fever, tachypnea and cough of approximately two weeks duration. At nine months of age she had been treated for left-sided pneumonia. A chest roentgenogram showed hyperinflation and patchy infiltrates of the left lung. She was treated again at 24 months of age for left lower lobe pneumonia. Chest roentgenogram at that time showed a streaky left lower lobe infiltrate, but no localized hyperinflation. She responded to treatment initially but again became ill with the presenting symptoms two weeks before admission. Her past history was unremarkable except for an exposure to tuberculosis (with two subsequent negative PPDs) and two episodes of otitis media. She was a quiet, thin, alert child in no distress. Temperature was 38.5°C orally, pulse 160 beats per minute, respiratory rate 60 per minute and weight 10.4 kg. She had a slight nonproductive cough. The chest examination revealed diminished breath sounds over the left hemithorax and decreased excursion and dullness to percussion at the left base. The remainder of the examination was unremarkable. The following laboratory values were obtained: WBC 20,000 with 57% polymorphonucleocytes, 9% bands, 29% lymphocytes, 4% monocytes, 1% eosinophils; 33.8% hematocrit; PaO_2 90 torr, PaO_2 22 torr, pH 7.53. An intermediate strength PPD was negative at 48 hours. Blood cultures were negative. Chest roentgenograms showed a large left lower lobe density with a marked shift of the mediastinum to the right. Sonography showed a large loculated fluid collection. Thoracentesis and chest tube placement yielded 120 cc of thick, tan-colored, purulent

The Authors
JONNI H. KLAPPER, M.D.
JAMES M. SHERMAN, M.D.
Drs. Klapper and Sherman are with the Department of Pediatrics at the University of South Florida College of Medicine, Tampa.

material which contained gram negative coccobacilli, no AFB, and had cell count of 331,000 WBC (96% polys), a protein of 5.26 mg/dl, glucose of 11 mg/dl, and an LDH of 34,776 IU/1. Cultures grew NTHI biotype III which was beta-lactamase positive, resistant to ampicillin and sensitive to chloramphenicol. At bronchoscopy no foreign body was found but the bronchial orifice of the superior segment of the left lower lobe was compressed. No active inflammation or purulent secretions were noted. Normal throat flora were cultured from bronchial washings. No NTHI were isolated. She was initially treated with penicillin G and subsequently switched to chloramphenicol which she received for three weeks. She responded rapidly to antibiotics. Subsequent chest roentgenograms showed resolving air-fluid levels with pulmonary cavitation and pleural reaction. She was admitted one month later for surgical removal of a suspected congenital cyst. A left lower lobectomy revealed a solitary peripheral congenital lung cyst of the bronchial type with no apparent communication to the bronchial tree. Her recovery was uneventful and she has had no further problems since then.

Discussion • A literature review reveals few reports of invasive infection by NTHI. NTHI may infect mucosal surfaces such as the bronchial tree, urogenital tract, or middle ear.[1] Bacteremia is unusual but has been reported in neonates[3] and debilitated adults.[2] In patients with cystic fibrosis, exacerbations have been associated with recovery of NTHI from tracheal aspirates and sputum cultures.[5] Seven cases of children with respiratory infections caused by NTHI have been reported since 1947 including three with empyema.[6-9] Hemophilus influenzae was recovered from a cavitary lesion and blood culture of a 25-year-old man but was not typed.[10]

NTHI is a frequent inhabitant of the pharynx in children and may contaminate cultures obtained by expectoration of sputum, bronchoscopy or transtracheal aspirates.[1,4,5,8] In our patient the culture was obtained by thoracentesis and the gram stain showed only one organism. NTHI is most commonly recognized as a respiratory pathogen in patients with chronic lung disease. Because of the prior abnormal roentgenograms, an abnormality was suspected in our patient. When no foreign body was found at bronchoscopy a congenital cyst seemed the most likely etiology of the localized hyperinflation. Because of the likelihood of future infection, the involved area was resected.

NTHI is frequently resistant to penicillin and ampicillin and should be considered as a potential pathogen in patients with underlying lung disease.

References

1. Riley, H.D.: Hemophilus influenzae Infections: Part II, Crit. Reviews in Clin. Lab. Sci. 15:227-333, 1981.
2. Berk, S.L.; Holtsclaw, S.A.; Wiener, S.L., and Smith, J.K.: Non-Typable Haemophilus influenzae in Elderly, Arch. Int. Med. 142:537-539, 1982.
3. Pickering, L.K. and Simon, F.A.: Reevaluation of Neonatal Hemophilus influenza Infections, So. Med. J. 70:205-207, 212, 1977.
4. Alibone, E.C.; Allison, P.R., and Zinnemann, K.: Significance of Hemophilus influenzae in Bronchiectasis of Children, Br. Med. J. 1:1457-1460, 1956.
5. Hoiby, N., and Kilian, M.: Hemophilus influenza from Lower Respiratory Tract of Patients with Cystic Fibrosis, Scand. J. Resp. Dis. 57:103-107, 1976.
6. Honig, P.J.; Pasquariello, P.S., and Stool, S.E.: Hemophilus influenza Pneumonia in Infants and Children, J. Pediatr. 83:215-219, 1973.
7. Liston, T.E. and Foshee, W.S.: Invasive Disease Due to Non-Typable Hemophilus influenza in Children, South Med. J. 75:753-754, 1982.
8. Soto, E. and Silverio, J.: Report of Five Children with Hemophilus influenza Pneumonia, Clin. Ped. 15:419-421, 1976.
9. Controni, G.; Chang, M.J.; Gold, B.G., and Rodriquez, W.J.: Haemophilus influenza Biotype III Infections in Children and Report of Three Unusual Cases, Am. J. Clin. Pathol. 76:718-720, 1981.
10. Wewers, M.D.; Hiller, F.C.; Wilson, F.J., and Bone, R.C.: Hemophilus influenza Infection of Existing Lung Cyst, South Med. J. 75:736-737, 1982.

• Dr. Sherman, Department of Pediatrics, University of South Florida College of Medicine, Box 15, 12901 N. 30th St., Tampa 33612.

For Your Benefit...

From The Florida Medical Association Sponsored Insurance Plans.

Diagnosis: FMA Members and Employees, Need Dependable, Comprehensive Coverage In Medical Care, Life, Disability and Dental At Economical Group Rates

Treatment: Enroll NOW in Your Florida Medical Association Sponsored Insurance Plans

Prognosis: Excellent. FMA-SIP Offers Flexibility, Convenience, Efficiency In An Insurance Package Designed Exclusively For You.

•Major Medical •Dental •Short-Term Disability •Life And AD&D

☐ Developed from your specifications by your Association and offered exclusively to FMA members and their employees. Dependents coverage available for Medical and Dental benefits.

☐ Marketing by Florida's leading insurance consultant, Brown and Brown, Inc., for further information contact us at the toll free number below.

☐ Underwritten by one of America's largest and strongest insurance companies, Mutual of Omaha.

☐ Administered by FLAMEDCO, Inc., highly regarded for rapid, efficient claims and enrollment administration and a wholly owned subsidiary of your own Florida Medical Association.

FMA/SIP Offers You Great Flexibility. You Choose The Coverage You Need:

Major Medical, Million-dollar protection with your choice of $200 or $500 annual deductibles and the new Medical Deluxe Plan.

Dental, Benefits of up to $1,000 per person each year. Optional if you elect Major Medical.

Life, Group term life insurance coverage for you and your employees. You select coverage level from $10,000 to $100,000.

Disability, If you elect life insurance, you also may choose from among four short-term disability options, either 13-week or 26-week coverage with or without maternity.

Call Toll-Free
1-800-624-3953 *For Details*

760 Riverside Avenue
Jacksonville, Florida



Florida Medical Association, Inc.
Sponsored Insurance Programs

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

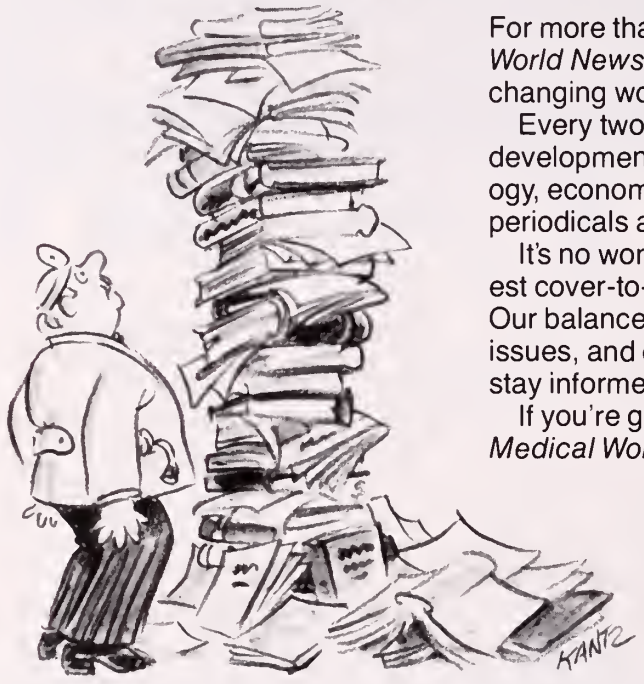
GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC. P.O. BOX 2411, JACKSONVILLE, FL 32203 TELEPHONE 904/356-1571

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

Getting behind in your medical reading? Let *Medical World News* put you ahead.



For more than 115,000 busy physicians like you, *Medical World News* is the secret to staying informed about the changing world of medicine.

Every two weeks, we will bring you up-to-the-minute developments in therapy, research, practice, pharmacology, economics, legislative action, highlights of other periodicals and new medical trends.

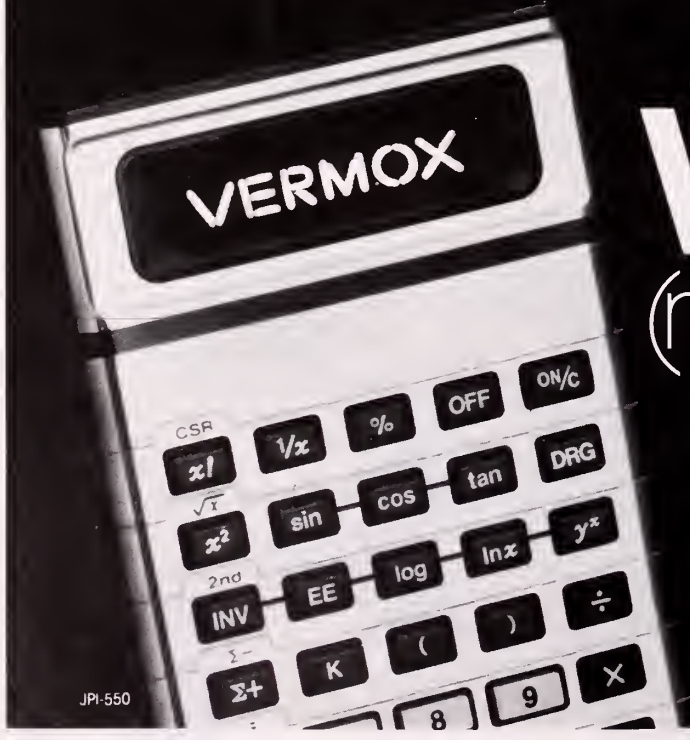
It's no wonder *Medical World News* has one of the highest cover-to-cover readerships in medical publishing today. Our balanced reporting means you'll get all sides of the issues, and our fast-reading style makes it enjoyable to stay informed.

If you're getting behind in your medical reading, let *Medical World News* put you ahead.

medical world news The credible source.

©1986 HEI Publishing. All rights reserved.

No need for dosage calculations...



VERMOX®
(mebendazole)

CHEWABLE TABLETS

JANSSEN PHARMACEUTICA

Piscataway, NJ 08854-3998

JPI-550

©. Janssen Pharmaceutica Inc. 1985

SPECIAL ARTICLE

Underground medicine: the widening problem of unlicensed physicians in the United States

Richard J. Feinstein, M.D.

Since at least 1940, there have been more applicants to medical schools in the United States than first-year places, and at least 50% of the applicants have always been unable to matriculate to the first-year class. In 1985 the ratio of about two applicants for each first-year position was maintained, and many U.S. medical educators feel strongly that if the ratio should ever be allowed to fall below two, the quality of individuals entering the medical profession would fall below an acceptable level.

There have always been a few American citizens who decided, for a variety of reasons, to pursue a medical education abroad, usually in a European nation. For at least 40 years there have been many foreign-born and educated physicians who chose to pursue postgraduate training followed by residence and a medical career in the United States. In fact, of the 550,000 physicians presently practicing in the United States, about 120,000 or 22% are graduates of foreign medical schools.

In order to evaluate the educational quality of foreign medical graduates, the Educational Commission for Foreign Medical Graduates, the ECFMG, was established in the 1950s to verify credentials and examine all foreign medical graduates prior to their admittance into U.S. hospitals for postgraduate training. The examination, referred to as the ECFMG test, was devised solely to evaluate the candidate's ability to function as a house officer under supervision of training faculty. TOEFL,Test of English as a Foreign Language, was included as part of the ECFMG to establish minimum English language skills for individuals who would serve as first-year residents at U.S. hospitals.

A new phenomenon, the proprietary foreign medical school existing almost exclusively for U.S. citizens who could not gain admission to U.S. schools, was first noted in the late 1970s with the opening of the St. George's School of Medicine on the Island of Grenada. Many other medical schools began to open in Caribbean nations and Mexico whose sole purpose was to provide a medical education to U.S. citizens who intended to return home for medical school clerkships, postgraduate education, licensure and practice.

U.S. medical educators and licensing boards had no way to anticipate the large number of individuals involved in this educational process and they were not generally prepared to properly evaluate these applicants for licensure. Licensing boards had traditionally relied heavily on the accreditation process of the school itself established by the Liaison Committee on Medical Education (LCME) for U.S. and Canadian medical schools. Boards also depended on reliable faculty evaluations of students, and objective independently prepared examinations, such as those offered by the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB) of the graduates of those schools.

The increase in number of proprietary medical schools in the Caribbean area and Mexico, the so-called offshore schools, took place just as the Graduate Medical Education National Advisory Committee (GMENAC) was preparing its report which concluded

The Author
RICHARD J. FEINSTEIN, M.D.
Dr. Feinstein is Clinical Associate Professor of the Department of Dermatology of the University of Miami School of Medicine, Miami.

that there were too many physicians in the United States and a surplus of 200,000 physicians could be expected by the year 2000. GMENAC predicted a surplus for almost all specialties and for almost all areas of the country. The report urged U.S. medical school deans to begin decreasing the size of their entering medical school classes. It also suggested that directors of residency training programs begin reducing the number of residency training positions.

Another important phenomenon that took place around the same time was a reduction in public financial support for medical education, hospital construction, and medical research. This was accompanied by Congressional budgetary concerns over the cost of health care in the nation, as the total national expenditure for health care approached 10% and then 11% of the Gross National Budget, and Medicare cost taxpayers over one billion dollars each week.

State medical boards began working feverishly to deal with the hundreds and thousands of applicants for licensure from the 20 or more brand new medical schools. Most of these applicants for licensure had spent their third and fourth medical school years at non-teaching community hospitals in large American cities or as preceptees who followed individual practicing physicians around for a month or two. Medical board members and medical educators could not sit idly by and allow this educational sham to fulfill licensing criteria. Students could not be expected to learn the four core medical school clerkships: medicine, surgery, pediatrics, and obstetrics-gynecology, at facilities or with individuals who had no expertise in medical education. Few boards, however, initially had any success in convincing their state legislators of the gravity of the problem.

While the Federation of State Medical Boards established its Commission on Foreign Medical Education to initiate a process to gather data and perform site surveys at foreign medical schools, individual state medical boards lobbied for new legislation to try to evaluate the graduates of those medical schools more thoroughly. Some states sought legislation requiring foreign medical graduates to take their third and fourth year medical school clerkships only at hospitals with a major medical school affiliation, house staff, and full-time teaching faculty. All state boards, except New Jersey, continued to maintain strong faith in the ECFMG examination and certification process, and all continued requirements for postgraduate training at an AMA-approved residency program followed by passage of the FLEX licensing examination. Some state boards, including New York and Texas, were able to have legislation passed that requires all foreign medical graduates to complete three years of postgraduate training instead of the one year required for U.S. graduates. Even if licensing boards could not evaluate the medical school and its faculty, they could at least impose a longer period of time for observation of foreign medical graduates prior to unrestricted licensure.

The Legislature in Florida would share none of its state medical board's concerns about the quality of the educational process at these schools, and over a period of five years the Legislature ignored annual pleas for legislative assistance in protecting the citizens of this state from improperly educated foreign medical school graduates.

The Florida Medical Board itself, by virtue of its rule-making authority, set a limit on the number of attempts any individual may have at passing the FLEX licensing examination. The Board itself by rule established guidelines for hospitals which could be acceptable for providing clerkships to third and fourth year medical students from offshore schools. The Board itself attempted to establish a forum to evaluate the medical education received by applicants for licensure by creating the Foreign Medical Graduate Advisory Committee which labored for untold hours prior to each regularly scheduled board meeting, interviewing candidates and verifying their credentials. Scandals involving the sale of transcripts and diplomae by certain offshore schools, such as CETEC and CIFAS, made the Medical Board's diligence in evaluating the graduates of these schools even more timely and important.

While many state legislatures, such as those in New York, California, Illinois and Texas, provided their state medical boards and their citizens with new legislation to help evaluate certain foreign medical schools and their graduates, the Florida Legislature acted in a reactionary fashion by making proposals to weaken rather than strengthen the State Medical Board's ability to select only qualified medical school graduates for licensure.

While many state legislatures, such as those in New York, California, Illinois and Texas, provided their state medical boards and their citizens with new legislation to help evaluate certain foreign medical schools and their graduates, the Florida Legislature acted in a reactionary fashion by making proposals to weaken rather than strengthen the State Medical Board's ability to select only qualified medical school graduates for licensure. Some legislative proposals made during the 1986 Florida legislative session include repeal of the need for foreign medical graduates to be certified by the ECFMG or take the FMGEM test; repeal of Board of Medical Examiners' rules esta-

blishing criteria for hospitals that are acceptable for providing clerkships for foreign medical students; repeal or rules governing the number of attempts an applicant may have at passing the FLEX test.

Florida legislators have instead proposed legislation that would make Florida the only state in the nation to reject the FLEX examination and reestablish our own state medical licensing examination; establish a foreign language examination, like the one that was used for Cuban immigrants in the early 1970s, and a medical prepartory course given in a foreign language for those preparing to take that test; offer a restricted medical license for those who are unqualified for a regular one, which would become unrestricted after just one year of supervised practice; and accord special status to licensure applicants who graduated from medical schools in nations that are hostile to the United States.

While the Florida Legislature has done little to help ensure that only competent foreign medical graduates are entitled to a medical license in this state, fortunately for our citizens, other forces are at work. The General Accounting Office (GAO), the fiscal arm of the U.S. Government, after doing onsite evaluations of several foreign medical schools in 1980 and again in 1985, concluded that the educational process at these schools was far inferior to that offered at U.S. medical schools. The GAO has recommended that the U.S. Department of Education and the Veterans Administration stop funding federally subsidized student loans and grants for students at these offshore schools. The GAO has also urged Congress to enact legislation that would establish an accreditation process for foreign medical schools, to be carried out by a private agency such as the LCME. Graduates of unapproved or unaccredited schools would be ineligible to seek training or licensure in the U.S.

Congressman Claude Pepper (D-FL) has recently proposed legislation to cut off Medicare funds for any hospital that employs house staff or faculty who are graduates of unaccredited foreign medical schools. Both the GAO and Pepper proposals are pending, and they may be swept aside in this year of Gramm-Rudman and Congressional elections, but unless state legislatures act appropriately, these proposals will continue to be brought back in subsequent Congressional sessions until the problem is solved. It is a shame that our state government is so mired in politics that Congress must intervene to protect Floridians from improperly educated foreign medical school graduates.

A significant barrier to the licensure of graduates of offshore medical schools will be imposed by directors of graduate training programs at accredited U.S. hospitals who have begun, for other reasons, such as the GMENAC report and funding cuts, to make limitations on the number of positions for first-year residents. All states except Florida require a PGY-I or internship at an AMA or ACGME (Accrediting Council on Graduate Medical Education) approved program as a requirement for licensure. Florida is the only state that allows five years of licensed practice in another state or country in lieu of an internship. Fewer first year residency positions and an increasing number of applicants have created an increasingly larger pool of medical school graduates who are unable to obtain a medical license. This phenomenon is now finally causing some reduction in the number of U.S. citizens who are applying for admission and attending proprietary foreign offshore medical schools, as the word filters down that an offshore medical diploma in itself may not guarantee a license to practice medicine in the United States.

There are about 69,000 students at the 127 U.S. medical schools, and about 17,000 graduate each year and seek a match for a residency position through the National Resident Matching Program. It is estimated that there are between 12,000 and 18,000 U.S. citizens at offshore medical schools,[1] and between 3,000 and 4,500 graduate each year and seek a position through the matching program. While over 95% of the graduates of U.S. medical schools obtain a position through the match each year, in 1985 only 40% of U.S. graduates of foreign medical schools matched, and only 22% of 7,000 alien foreign medical graduates were able to match. Failure to match and obtain a position in an AMA approved first-year residency results, in almost all cases, in an inability to obtain a medical license because at least one postgraduate year is a requirement for licensure in every state except Florida.

medical graduates has been the standardized medical examinations provided by the ECFMG and the FSMB. The ECFMG began using a new examination, the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) in July 1984. Of the 21,026 foreign medical graduates who took both days of the FMGEMS in July 1984, January 1985, and July 1985, 3,280 or 15.6% passed, and 84.4% or 17,746 did not pass, remaining ineligible for postgraduate training and licensure.[2]

Of the American foreign medical graduates who took the examination for the first time, 23.8% passed in July 1984; 18.1% in January 1985; and 16.8% in July 1985. Of the 3,520 who failed and repeated the examination during these periods, 162 or 4.6% passed.

What is emerging from these data is the troubling reality that there is developing in this country a very large pool of individuals who believe that they are physicians because they possess a medical degree from an institution in a Caribbean nation or Mexico which calls itself a medical school. These individuals, because they are unable to pass a standardized examination, such as the FMGEMS or FLEX, or gain acceptance to a postgraduate training program through the National Resident Matching Program, will participate in a vast subculture of underground medicine

in this nation which is inhabited by people who want to practice medicine, although they lack the license and credentials to legally do so.

As many as 50,000 unlicensed physicians live in this country in the subculture of underground medicine.

A study published in 1974[3] of 4,000 foreign medical graduates who took the January 1973 ECFMG test found that 48% were already working in the health field although none were yet licensed. Of these, 73% were involved in direct patient care, and 64% were working in hospitals. A large number were functioning independently and unsupervised, performing histories and physicals, taking night calls, covering emergency rooms, doing general medical practice, and writing orders and prescriptions.

While state legislators and the public debate the possible relationship between the malpractice insurance crisis and incompetent doctors and weak medical regulatory boards, thousands of improperly educated graduates of unaccredited foreign medical schools have been able to obtain a valid medical license because legislators see political motivations in everything. As many as 50,000 unlicensed physicians live in this country in the subculture of underground medicine. The number in Florida may be particularly high because of the large number of urban clinics that have had a traditional propensity for hiring unlicensed health care personnel, and because of the increased availability of health related jobs for non-English speaking physicians in many Florida locations. There is an increased risk that these uncredentialed and unlicensed physicians will harm patients, and although such medical mishaps may not result in malpractice suits and large jury verdicts that can be measured by commissions studying malpractice data, the incompetent medical care will invariably result in harm to citizens of this state who will require the expenditure of time and money to restore them to good health.

The Department of Professional Regulation received 50 complaints in 1980-81 concerning unlicensed medical practice, and this number rose to 74 in 1983-84 and 115 in 1984-85. Some of these complaints are invariably made against uneducated frauds who aspire to work as physicians, but I believe that an increasing number of complaints will be directed against unlicensed foreign medical school graduates who believe that they are entitled to practice although they lack the official recognition by this state to do so.

It is a terrible tragedy for these offshore medical school graduates who are unable to obtain a medical license, and I have real empathy and sadness for their plight. It is also a tragedy for patients who may visit them in the belief that they are licensed medical doctors. This tragedy was created by entrepreneurs who opened offshore medical schools as a way to make a profit or provide a medical education for a relative or friend. The tragedy was compounded by our state legislators who failed to act quickly and effectively to stop the mockery of medical education and licensure that these schools represent. Instead, by failing to act, our leaders encouraged the continued existence of these mock medical schools, giving false hope to thousands of Americans who had dreamed, perhaps even from childhood, of one day attending medical school and becoming medical doctors. Few humans are capable of fulfilling all their dreams, and there are thousands of individuals who were admitted to offshore medical schools although they lack the intellect and other skills necessary to become licensed physicians in the United States. They now possess a piece of paper, which they believe to be a valid medical degree, which has cost them dearly in money, time and effort, and some of these individuals will spend the rest of their lives trying to obtain a medical license or working in a hospital or clinic without one. Some will maintain strong hostility toward the medical profession in this country, especially toward medical educators and medical licensing board members, whom they believe have improperly conspired to prevent them from practicing their chosen profession. Their acquaintance with medical information and their frustration and anger may continue to create difficulties for society and themselves.

I must state emphatically that members of the Florida State Board of Medical Examiners have never been part of any conspiracy to blindly restrict access to licensure and medical practice to foreign medical graduates or any class or group of physicians based upon anything but demonstrated competence and eligibility for licensure under the statutes and board rules. We have only attempted to carry out our legislatively mandated responsibilities to protect the people of Florida from incompetent and unethical medical practice. As acknowledged authorities in the areas of medical licensing and discipline, we naively believed that the members of the Florida Legislature would afford us the credit and respect for making recommendations for statutory changes to more efficiently regulate the licensing and discipline of physicians, and protect the citizens. Instead, the Legislature has chosen to listen to the opinions of several hundred disgruntled graduates of offshore medical schools who are unique only in their inability to make a passing grade on the ECFMG and FLEX tests, and their inability to gain admission to an approved first year residency position.

The intense loyalty and dedication of time and effort which characterize the service of physicians who serve on the State Board of Medical Examiners come only from a desire to do an appointed job well.

There has never been any consideration or discussion, as has been alleged, that we have rejected applicants because of a real or perceived surplus of physicians, or as a method of maintaining a monopoly on medical care as a way to earn large incomes.

There is an increased risk that these uncredentialed and unlicensed physicians will harm patients, and although such medical mishaps may not result in malpractice suits and large jury verdicts that can be measured by commissions studying malpractice data, the incompetent medical care will invariably result in harm to citizens of this state who will require the expenditure of time and money to restore them to good health.

When I leave the Florida Board of Medical Examiners this summer, as my second and last term ends, I will leave behind the problems of fraudulent medical school transcripts and diplomas; of corrupt medical school officials and incompetent faculties; of offshore medical school admissions officers who advertise in American newspapers and admit everyone who applies who has the money for tuition; of the scandalous lack of adequate facilities and the burlesque offered as a legitimate medical education; of preceptorships and community hospital mock-clerkships; of aggressive parents, sometimes physicians themselves, who demand that their children obtain a medical school degree without regard to the quality of their education; of some foreign graduates themselves who prefer to obtain a medical license by lobbying legislators instead of getting a proper education and passing the standard examinations; of nasty and pompous legislators, consumed with their own sense of importance, who sponsor any legislation for a promise of two votes, and who consider themselves heroes and protectors of the downtrodden and suppressed; of the unlicensed physicians practicing illegally in urban prepaid health care clinics or rural communities.

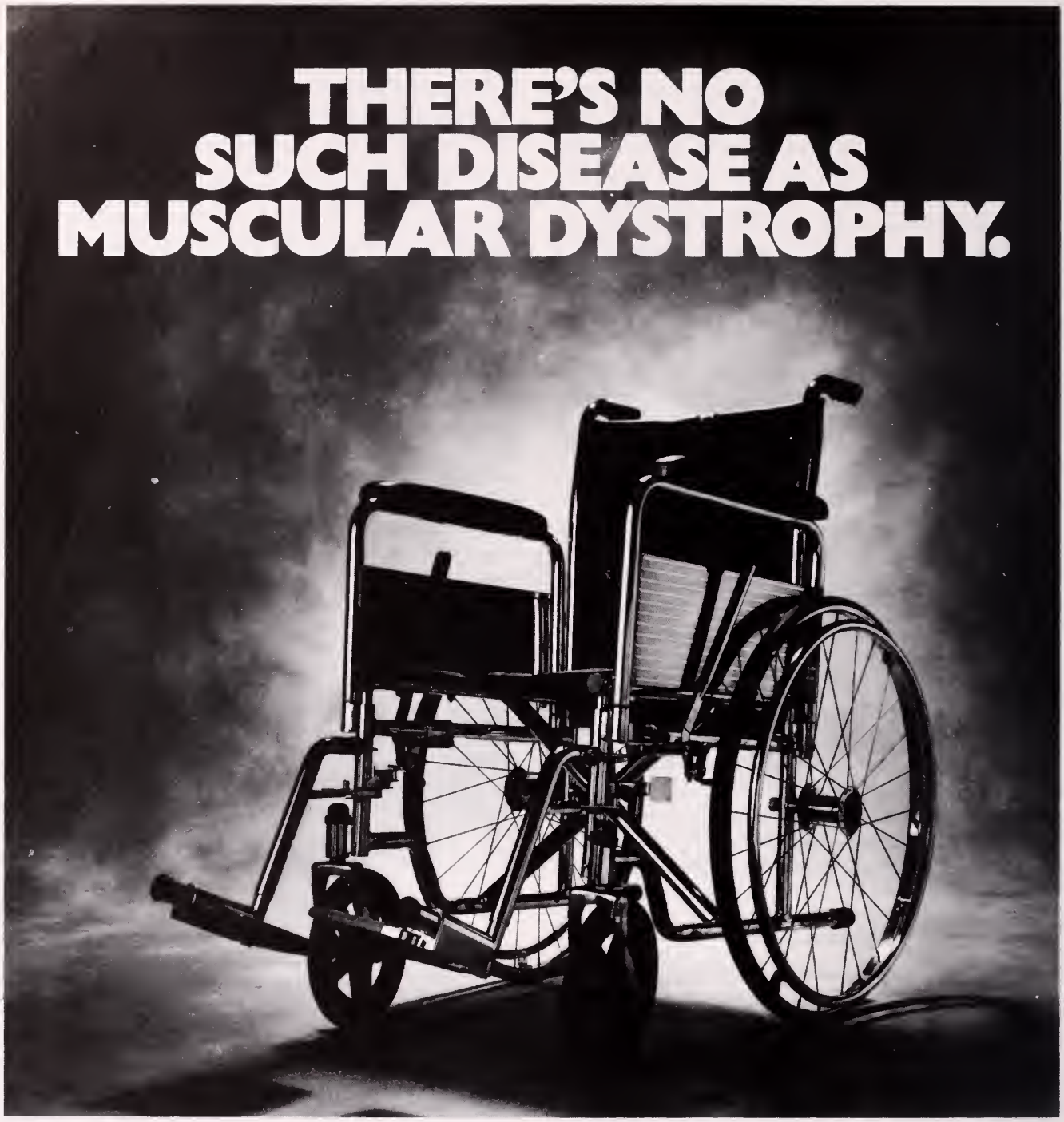
These matters will no longer be my concern, and I, like other members of the medical board whose terms have expired, will devote my time and energies to my family, patients and other matters. I will know which physicians to refer my family, friends and patients to when they are in need of medical care. I will also understand that incompetent and unlicensed physicians are practicing medicine in this state on the elderly and the poor, because our elected leaders lacked the courage to quickly block the development of unqualified medical schools that have existed only to beat the system, but it will be someone else's problem.

References

1. Feinstein, R.J.: United States Citizens at Foreign Medical Schools, J.F.M.A., Vol. 69, 10:865-870, October 1972.
2. Galusha, B.L.: The Role of Medical Licensure Boards in Credentials Verification, Federation Bulletin, Vol. 73, 4:99-114, April 1986.
3. Weiss, R.J. et al: The Effect of Importing Physicians — Return to a Pre-Flexnerian Standard, N.E.J.M., Vol. 290, 26:1453-1457, June 27, 1974.

- Dr. Feinstein, 3661 S. Miami Ave., Suite 1002, Miami 33133.

THERE'S NO SUCH DISEASE AS MUSCULAR DYSTROPHY.



It's true. Because "muscular dystrophy" is the term for a *group* of twelve diseases—and no one disorder goes by that name.

Other facts about muscular dystrophy might surprise you, too. For one thing, the diseases aren't restricted to children. Anyone can be stricken, at any time.

For another thing, the Muscular Dystrophy Association battles not just the twelve muscular dystrophies, but twenty-eight other neuromuscular diseases, too.

At MDA, we're striving to put an end to all the devastating disorders you used to think of as muscular dystrophy.

And one day—we're determined—this chair will be empty for real.

MDA

Muscular Dystrophy Association, Jerry Lewis, National Chairman

Peer review organizations: what is the record so far?

Many physicians complain that the Orwellian fantasy in which the tentacles of government slither more menacingly amidst the activities of our daily lives has been transmuted from phantasm into reality. They point to Peer Review Organizations as the embodiment of the political interference by medically ignorant government hirelings into the patient care realm. A decade ago, physicians rested comfortably with the assumption that medicine was practiced by doctors who were appropriately educated and licensed, and that decisions regarding care of the sick were reserved to the judgement of such highly trained and skilled individuals. Today, many decisions regarding patient care, particularly in regard to the propriety of hospitalization or the performance of some procedures, are being made by non-physicians who lack appropriate medical knowledge.

Concern about the quality and the cost of medical care is appropriate. Shortly after the introduction of Medicare and Medicaid, Congress attempted to assure proper utilization and quality of medical care. Unfortunately, the original review processes, which were conducted by hospital staffs and insurance companies, failed. Starting in 1972, 187 Professional Standards Review Organizations (PSROs) were instituted throughout most of the United States. Ostensibly their purpose was to assure the quality of medical care and to prevent overutilization. However, the criterion for success of the PSRO process was measured by cost savings data; quality concerns were neglected. The credibility of the PSROs was severely compromised by other considerations. For instance, review decisions were frequently left to the discretion of unlicensed physicians, to doctors who lacked medical society membership or approval, and to doctors whose lack of expertise in a given discipline rendered them unfit judges for the review process. The medical establishment therefore decried the PSROs and by 1982 the Reagan administration decided to eliminate them. However, Congress disagreed with the administration and decreed that some form of review organization should oversee the Medicare/Medicaid programs. In 1984 the Health Care Financing Administration (HCFA) began contracting with a smaller number of review associations and renamed them Peer Review Organizations (PROs). The majority are first-generation progeny of PSROs and oversee the Medicare/Medicaid program in 54 areas in the United States. The Professional Foundation for Health Care Services in Tampa has responsibility for the entire state of Florida.

Each PRO contractor proposed a program that would both produce cost savings and increase quality of care (as measured by reduction of unnecessary mortality and morbidity).

The cost-saving goals have focused upon reducing all unnecessary admissions and diminishing the performance of unnecessary procedures. For instance, surgical admissions for operations that could be performed outside the hospital are to be eliminated. Institutions and/or physicians who are judged to inappropriately use hospitalization or procedures are to be identified and threatened with loss of Medicare participation. Attempts have been made to reduce unnecessary x-rays and laboratory testing; DRG categorizations have been validated to prevent "DRG creep," that is, the substitution of a higher paying DRG code for a lower paying code; all patient transfers from one hospital to another; all "cost" and "day" outlyer cases, all readmissions that occur within seven days after discharge, and all cardiac pacemaker implantations are reviewed. Additionally, the medical

necessity for selected procedures and DRG diagnostic codes are targeted by individual PROs for examination. Admissions for cosmetic and for custodial purposes are summarily disallowed.

The Florida PRO has concentrated its cost saving efforts towards decreasing hospital admission for ocular lens implantation, for carpal tunnel release, and for certain podiatric procedures. It has also attempted to reduce the numbers of thyroid scans and the numbers of intravenous pyelograms used for hypertension workups. It contracted with HCFA to eliminate 54,000 "unnecessary" admissions for lens implant procedures over a two-year period. The Florida PRO has exceeded this goal. It has eliminated 97% of inpatient admissions for lens implant procedures that could be done on an outpatient basis during the last two-year period.

The Florida PRO has concentrated its cost saving efforts towards decreasing hospital admission for ocular lens implantation, for carpal tunnel release, and for certain podiatric procedures.

To conduct its review work, the Florida PRO employs 189 staff people. The majority of these are registered nurses. A smaller number of assistant record technicians and registered record administrators are also used. Two hundred and sixty-four physicians consult part-time at a rate of $56 per hour and review specific cases. The PRO reports that all physicians are licensed in the state, all have staff privileges at one or more hospitals and most, but not all, have been approved by a local medical society. Most are also board certified.

The Florida PRO examines from 5-100% of all Medicare and Medicaid admissions. Admissions that fall into the 100% review category are cases of uncomplicated diabetes (both insulin and non-insulin dependent), impacted ear wax, benign hypertension, cases of increased blood pressure that lack a diagnosis of hypertension, left bundle branch block, right bundle branch block, and other complications of medical care. It reviews all transfers from DRG-regulated hospitals to psychiatric units, to rehabilitative centers, or to alcoholic-care centers. Additionally, it randomly selects about 5% of all other Medicare/Medicaid admissions for examination. Altogether the Florida PRO personnel review about 35% of all Medicare/Medicaid admissions.

Has the PRO cost-containment effort been successful nationally? National data are not available but should be reported within the next year. The Florida PRO has revealed some of its data to me. Since its establishment there has been significant cost savings in Florida in at least one area — that from reducing admissions for lens implants. Statistics obtained from HCFA and Blue Cross/Blue Shield indicated that 8,194 admissions for ocular lens implants in Florida during the first quarter of 1984 could have been performed outside of the hospital. During the first quarter of 1986, 18 months after the establishment of the Florida PRO, only 170 admissions for lens implants were judged to be unnecessary — a reduction of 98%. This represents a cost savings of over $9,000,000 per year to Medicare. Since the PRO budget is $7,000,000 per year the Florida PRO appears to be cost-effective. Data concerning reductions in unnecessary admissions for other illnesses or procedures have not been analyzed for this article.

The critical issue in evaluating the outcome of the national PRO cost containment agenda is the assessment of the PRO role in accomplishing these savings. Both the rates of hospital admissions and the length of hospital stays have been dropping for seven years while PROs have been operating for less than two years. Attribution of a majority of the cost savings to the operations of PROs (or even to the imposition of DRGs) is questionable. The reduction in hospital admissions and duration of stay may have approached current levels in the absence of PROs. Unfortunately the numbers to assess the relative contributions of the continued decline in hospitalization which had previously been established, of DRGs, and of PROs to these savings is unavailable. Certainly the cost effectiveness of PROs must be more rigorously established. A secondary issue that must be acknowledged in evaluating the cost effectiveness of PROs is the inaccuracy of the data collected for the baseline period prior to PRO existence. This issue of questionable data is discussed below.

The contract price for the national PRO system exceeds 300 million dollars per year. Certainly a mechanism that will appraise the cost-reward ratio of PROs should be instituted if PROs are to be allowed to survive in this era of government-spending restraint.

Denial of payment of admissions is a major cause of agitation between PROs and physicians and hospitals. The most recent quarterly report from the Florida PRO stated that approximately 1,500 admissions were denied during the quarter. Of these, 721 were appealed and 249 of the 721 (35%) of the appealed cases were reversed, i.e., the denial decision by the PRO was overturned in about one third of the cases in which the decision was contested. The reasons for admission denial are multiple. Cosmetic and custodial care, failure to adequately document the necessity of admission, diagnostic work-ups, and admissions for procedures that could have been performed on an outpatient basis are the most prevalent reasons.

In addition to reducing expenses, the PROs have been mandated to assure an improved quality of

patient care. Major quality objectives are: to reduce unnecessary readmissions that result from inadequate care during a previous admission; to reduce avoidable death; to reduce unnecessary surgery and other invasive procedures; to avoid post-operative and other complications of hospitalizations such as infection; and to ensure provision of proper medical care.

HCFA also allows each PRO to establish its own additional quality control objectives and activities. The Florida PRO identifies hospitals and physicians that it feels are providing substandard care. Each case is reviewed by a physician panel. If this panel concurs that defects in quality of care are present and persistent, then the hospital or physician is sent a letter that states the PRO complaints and requests a plan of action by which the hospital or doctor will correct the deficiencies. If the hospital or physicians do not comply, then they can be excluded from reimbursement for the care of Medicare/Medicaid patients. Until now, one Florida hospital has voluntarily withdrawn from the Medicare/Medicaid program, 11 Florida physicians have been requested to correct the conduct of their medical care; and one physician has been threatened with exclusion from the Medicare/Medicaid program. Medicaid program.

Florida PRO identified an excess of deaths from sepsis during the baseline 1983-1984 period. It drew up and published a list of recommendations for the management of sepsis. Compliance with the recommendations has been better than anticipated. It is estimated that 241 deaths from sepsis have been prevented by the sepsis control program.

The first step in providing quality is to define it and measure some outcome of patient care. Measurement requires the accumulation of accurate data and the comparison of the accumulated data with some standardized reference. There are statistical problems in fulfilling this initial step. Accurate data accumulation has not, and is not being, performed. Furthermore, national data banks for most medical conditions are flawed with imperfect data. An example of this problem was experienced by the Kentucky PRO. The Federal data base obtained from HCFA indicated that the mortality for myocardial infarction in Kentucky during 1983 was 29%. This compared unfavorably with the national mortality rate of 24% and a regional rate of 25%. The Kentucky PRO was assigned the objective of reducing its myocardial infarction fatality rate to that of the rest of the nation. The Kentucky PRO more closely analyzed the Kentucky data obtained from HCFA that applied to 1983 and discovered major discrepancies within it. Many of the excessive myocardial infarction deaths were either not deaths or did not occur during the 1983 baseline period. Coding errors mistakenly attributed deaths to myocardial infarction when the deaths actually resulted from other conditions. In over one fifth of deaths, the diagnosis of myocardial infraction could not be confirmed by clinical criteria. Therefore, a more penetrating inspection of the original HCFA data demonstrated that the inflated myocardial infarction mortality rate in Kentucky is nonexistent and is an artifact of faulty computer data base information.

Assessment of quality requires more than the tabulation of data that resides in computer storage. The quality of the data obviously affects the output. PRO data quality is tainted by at least three sources of error: the precision of the data entry processes, the accuracy of the data being inputted, and the absence of modifying factors. Each of these adversely affects the information being recorded. For example, data entry by keypunch operators or other computer personnel is attended by a 3-5% error. An additional 20% error rises from the poor quality of the data given to the computer techinician. These inaccuracies exist because of coding errors committed by medical record technicians and by physicians' failure to properly identify all diagnoses or procedures performed. Another source of errors stems from the retrospective method in which PRO data acquisition is obtained. This permits intrusion of additional misjudgements. These multiple sources of misinformation do not mutually cancel one another; rather they compound inaccuracies and the statistical reports.

These concerns about data purity are not merely academic musings. Information that emerges from the PROs will be published and publicized. Publications of faulty statistics can pervert the public's image of an institution and can potentially harm an institution financially. For instance, Johns Hopkins Hospital was reported to have the highest mortality rate from cholecystectomy in the state of Maryland. An inquiry into the statistics revealed multiple data entry mistakes that artificially exaggerated the death rate. When the statistical data was corrected, the Hopkins cholecystectomy mortality rate matched that of surrounding hospitals.

Morbidity and mortality rates must be adjusted so that they account for differences in the health of the patient populations served. Hospitals that care for more critically ill, indigent, and more elderly patients will experience higher morbidity, mortality, and complication rates than those who care for such individuals less frequently. Therefore morbidity and mortality statistics that fail to account for these patient population differences will provide us no help in assessing quality of care. The current PRO and DRG systems lack disease-modifying indicators. Thus its data will not correctly provide a basis of comparison of quality of care among institutions.

Differences in the enthusiasm with which institutions discover and report complications of procedures and hospitalizations will also impair accurate comparisons of care quality among hospitals. For instance, a hospital that has an active, aggressive

infection surveillance program will uncover more hospital-acquired infections and therefore will appear to experience a higher nosocomial infection rate than an institution whose surveillance system is less ambitious. The hospital with a quality surveillance program will find more infections, report a higher infection rate and may superficially appear to have a significant infection problem where none really exists. However, quality depends upon a good surveillance system so that infections can be eradicated before a more serious problem does develop.

Another criterion of quality medical care used by the PROs is the frequency of readmission within seven days after discharge. The assumption underlying the use of this criterion is that readmission reflects a lack of proper care during the original admission. This assumption is also flawed. Certain types of patients, such as diabetics and alcoholics, frequently will be readmitted after hospitalization because of lack of compliance with the medical program prescribed for them. This pattern is most commonly observed within the indigent patient population. Institutions that care for a disproportionately large number of indigents will experience a readmission rate higher than that of other hospitals. Thus this quality criterion also needs to be modified.

Therefore, gross problems exist in the national PRO program. It is unknown if it saves money for the government; it is highly doubtful that it can accurately measure quality. Its ability to improve or assure quality remains nothing more than questionable speculation.

Quality assurance and the elimination of profligate spending from the health care system are noble and necessary aims. Doubts exist in the minds of some health care scholars as to the ability of the PRO system to accomplish these goals. The current program costs the government more than 300 million dollars per year to administer and costs our hospitals additional untallied millions to comply.

The initial two-year contracts for PROs expire between now and November 1986. This might be an appropriate moment to jettison the current system and substitute for it a series of economic experiments designed to establish the best means of assuring quality and eradicating prodigality. These experiments should be conducted prospectively in a controlled fashion by recognized health care scholars. The

Gross problems exist in the national PRO program. It is unknown if it saves money for the government; it is highly doubtful that it can accurately measure quality. Its ability to improve or assure quality remains nothing more than questionable speculation.

presently existing high-quality PROs could be employed to participate in this research. Hopefully, physicians who both understand the medical conditions and the dangers inherent in the diseases that afflict our patients and also possess integrity and commitment to medical-care excellence will provide the leadership for such experiments. Knowledge harvested from such carefully constructed research should provide us with improved ability to monitor the quality and cost of health care.

References

1. Dans, P.E.; Weiner, J., and Otter, S.: Peer Review Organizations: Promises & Potential Pitfalls, N.E.J.M., 313:1131-1136, 1985.
2. Richardson, D.; Main, K., and Graves, S.: Peer Review Organizations, N.E.J.M., 314:1121, 1986.
3. I am indebted to Ms. Susanne Snyder, the Executive Director of the Professional Foundation for Health Care Services, for providing me data and information concerning the Florida PRO.

Jacques R. Caldwell, M.D.
Daytona Beach

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

THE MEDICAL SYSTEM INCLUDES:
- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

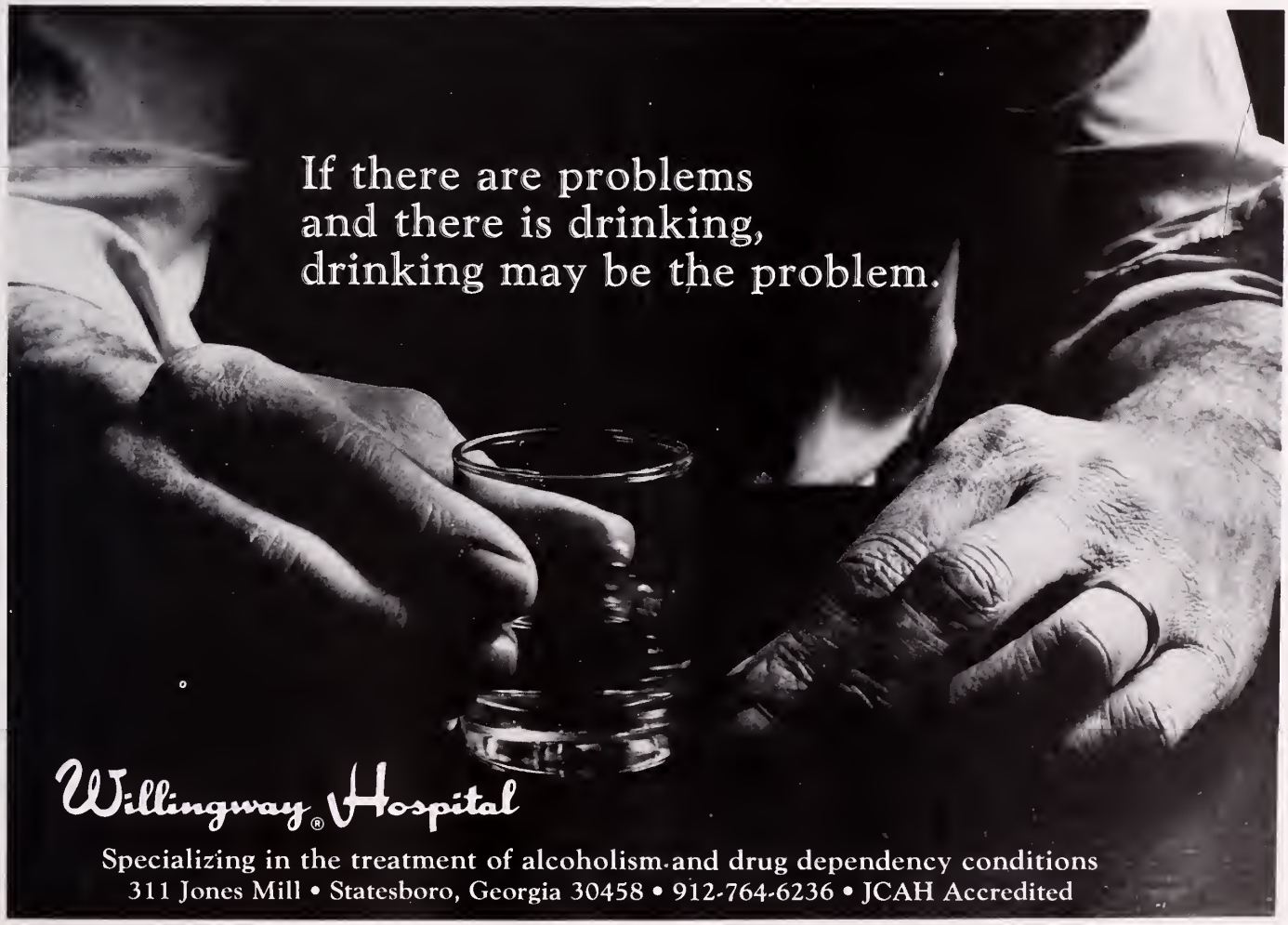
ADVANTAGES
- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

INTERESTED?
For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

The ISI Software Question

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.



An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

29 Glen Cove Ave., Glen Cove, N.Y. 11542 516-676-4300

Our members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
American Health(10)	14.95	12.95	11.95	
American Heritage(6)	24.00	18.00	18.00	
Amer.Photographer(12)	19.90	9.95	6.65	8
Americana(6)	11.95	11.95	9.95	
ArtNews(12)	29.95	25.95	25.95	
Artist's Mag(12)	21.00	21.00	9.97	9
Atlantic Monthly(12)	9.95	9.95	9.95	
Audio(12)	17.94	8.97	8.97	
Baseball Digest(12)	14.95	14.95	7.97	10
Basketball Digest(8)	9.95	9.95	7.97	
#Better Hms-Gdns(12)	12.97	6.49	12.97	
#Bicycling(10)	15.97	8.00	12.97	
Black Enterprise(12)	15.00	9.00	7.50	
Bon Appetit(12)	15.00	15.00	15.00	
Boys Life(12)	13.20	13.20	11.97	
Car & Driver(12)	17.00	11.99	11.99	
Cats (12)	17.50	17.50	12.50	
Cat Fancy(12)	17.97	17.97	12.97	
Changing Times(12)	15.00	9.97	9.97	
Child Life:age 6-10(8)	11.95	11.95	9.97	
Childrens Dig:7-11(8)	11.95	11.95	9.97	
Commentary(12)	33.00	33.00	33.00	
#Connoisseur(12)	19.95	10.00	19.95	
Consumers Digest	14.97	14.97	10.97	
Consumers Reports(12)	16.00	16.00	16.00	
#COSMOPOLITAN(12)	**24.97**	**15.00**	**24.97**	
Cruising World(12)	18.00	18.00	14.00	
#Discover(12)	24.00	13.00	14.95	
Dog Fancy(12)	17.97	17.97	12.97	
Downbeat(12)	15.75	15.75	7.95	
Ebony(12)	16.00	14.00	9.97	
The Economist(52)	85.00	51.00	51.00	
Ellery Queen Myst(13)	22.75	19.50	9.97	10
Esquire(12)	17.94	9.95	9.95	
Essence(12)	12.00	9.96	9.00	
Family Circle(17)	14.97	14.97		
Family Computing(12)	19.97	11.97	11.97	
Family Handyman(10)	9.95	9.95	5.95	
Field & Stream(12)	13.94	7.94	7.94	
Fifty Plus(12)	15.00	11.97	11.97	
Financial World(26)	41.95	24.94	18.95	18
Food and Wine(12)	18.00	9.00	15.00	
Football Digest(12)	12.95	12.95	7.97	10
Forbes(28)	42.00	42.00	28.00	
Fortune(26)	42.00	21.00	21.00	
Games Magazine(12)	15.97	15.97	15.97	
Gentlemens Quart.(12)	18.00	13.50		
Glamour(12)	15.00	12.00		
Golf Digest(12)	19.94	11.97	11.97	
Golf Magazine(12)	15.94	8.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Good Housekeeping(12)	14.97	9.97	14.97	
Gourmet(12)	18.00	13.50	15.00	
#Harpers Bazaar(12)	16.97	8.97	16.97	
Harpers Magazine(12)	18.00	**9.97**	**9.97**	
Health(12)	22.00	13.32	11.00	
High Fidelity(12)	13.95	6.98	6.98	
Home(12)	15.00	15.00	15.00	
Home Mechanics (12)	11.94	8.97	8.97	
The Homeowner(10)	18.00	13.97	9.00	
Hot Rod(12)	13.94	8.97	8.97	
House and Garden(12)	24.00	18.00		
#House Beautiful(12)	15.97	7.99	15.97	
Humpty Dumpty:4-7(8)	11.95	9.97	9.97	
Jerusalem Post(24)	18.46	18.46	15.97	
Jet(52)	36.00	30.00	26.00	
Ladies Home Jrnl(12)	20.00	15.00	10.00	
#Life(12)	32.50	16.25	25.00	10
M:Civilized Man(12)	24.00	19.95	17.95	10
Mademoiselle(12)	15.00	12.00		
#McCalls(12)	11.95	11.95	11.95	
Metropolitan Home(12)	15.00	7.50	7.50	
Modern Photography(12)	13.98	7.98	6.99	
#Muney(12)	29.95	15.00	19.95	
Mother Jones(12)	18.00	12.00	12.00	
Motor Trend(12)	13.94	7.97	7.97	
MS Magazine(12)	16.00	10.97	10.97	
The Nation (52)	28.00	28.00	9.95	24
Nation's Business(12)	22.00	12.97	12.97	
Natural History(12)	20.00	15.95	15.95	
N.E.Journal of Medicine(52)	60.00			
New Republic (52)	48.00	48.00	28.00	
#New Shelter(9)	10.97	5.50	9.97	
N.Y. Rev.of Books(17)	28.00	28.00	25.95	
New Yorker(52)	32.00	32.00	20.00	
#Newsweek(52)	41.00	21.80	21.80	
Omni(12)	24.00	15.96	15.96	
1001 Home Ideas(12)	22.00	15.97	11.00	
Organic Gardening(12)	12.97	9.97	9.97	
Outdoor Life(12)	13.94	7.97	7.97	
Outside(10)	16.00	12.00	8.97	
Ovation(12)	16.00	8.00	8.00	
PARENTS(12)	18.00	**9.00**	**11.95**	
Penthouse(12)	36.00	30.00	30.00	
People(52)	56.50	56.50	28.25	
Personal Computing(12)	18.00	18.00	8.97	9
Petersens Photog(12)	13.94	6.97	6.97	
Playboy(12)	25.00	21.50	21.50	
#Popular Mechanics(12)	13.97	7.00	13.97	
Popular Photogr.(12)	11.97	5.99	5.99	
Popular Science(12)	13.94	7.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Prevention(12)	13.97	7.00	13.97	
Psychology Today(12)	15.99	8.00	12.97	
Reader's Digest(12)	15.41	15.41	15.41	
#Redbook(12)	11.97	6.97	11.97	
Road and Track(12)	17.94	11.99	12.99	
Rolling Stone(26)	19.95	19.95	17.95	
The Runner(12)	16.97	12.97	8.97	
#Runner's World(12)	19.95	10.00	12.97	
Sail(12)	21.75	21.75	21.75	
Saturday Eve.Post(9)	12.97	12.97	12.97	
Savvy(12)	12.00	12.00	6.00	
Science '86(11)	18.00	18.00	13.95	
#Science Digest(12)	13.97	6.99	13.97	
Scientific Amer.(12)	24.00	24.00	24.00	
Self(12)	15.00	12.00	N.A.	
Seventeen(12)	13.95	13.95	13.95	
Shape(12)	20.00	20.00	8.97	6
Ski(8)	11.94	6.97	6.97	
Skiing(7)	9.98	4.99	4.99	7
Skin Diver(12)	13.94	7.97	7.97	
Sport(12)	12.00	7.97	7.97	
Sporting News(24:6 mo)	22.50	11.97	11.97	
#Sports Afield(12)	13.97	6.99	13.97	
#Sports Illustr.(54)	56.50	34.00	29.45	
Stereo Review(12)	9.97	4.99	4.99	
Teen(12)	12.95	7.95	7.95	
Tennis(12)	17.94	8.97	8.97	
#Time(52)	58.25	29.25	28.00	50
#Town & Country(12)	24.00	12.00	24.00	
Travel & Leisure(12)	25.00	12.50	25.00	
TV Guide(52)	31.20	31.20	26.00	
#U.S.News/Wrld.Rep(52)	41.00	20.50	20.50	
Vegetarian Times(12)	19.95	14.95	14.95	
Video(13)	15.00	15.00	7.50	
Video Review(12)	12.00	6.97	6.97	
Village Voice(52)	32.76	32.76	22.00	
Vogue(12)	24.00	21.00		
W Magazine(26)	26.00	23.00	17.95	
Weight Watchers(12)	13.97	11.97	11.97	
Woman's Day(17)	15.13	15.13	15.13	
Women's Sports(12)	12.95	12.95	8.95	
Workbench(6)	6.00	6.00	5.00	
Working Mother(12)	11.95	9.95	9.95	
Working Woman(12)	18.00	12.00	15.00	
World Press Review(12)	16.95	16.95	14.98	
Writer's Dig.(9 iss)	18.00	9.97	9.97	
Yankee (Colonial)(12)	15.00	15.00	12.97	
YM(12)	14.00	10.95	10.95	

#BUSINESS CARD NEEDED FOR OFFICE PRICE				

HUNDREDS OF OTHER TITLES AVAILABLE! PLEASE SEND US YOUR REQUESTS!

FMA MAGAZINE PROGRAM
29 Glen Cove Ave., Glen Cove, N.Y. 11542

MAIL MAGAZINES TO:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AFFILIATED HOSPITAL/SCHOOL _____
Required for Educator rates

VISA or M/C No. _____ Exp. Date _____

Prices subject to publishers' changes.

PLEASE SEND THE FOLLOWING MAGAZINES:

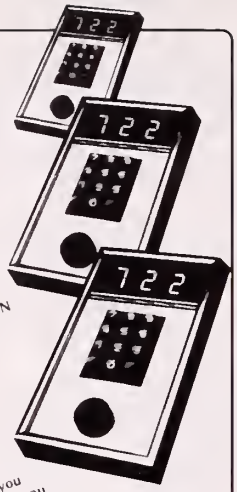
NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

All subscriptions are for one year unless otherwise noted
Guarantee: Our prices are the lowest, our service the best.
New Orders: Publishers take from 6 to 12 weeks to start your subscription
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.

Please make checks payable to: FMA Magazine Program

FLMD186

The Message Is Silent ... The Message Is Everywhere!



THAT IS DIGIT-UP® SILENT DIGITAL COMMUNICATION
SILENT AND EVERYWHERE!

Doctors in large solo practices and group practices are reporting Digit-Up's® 3 digit codes to be adaptable to their individual needs and virtually unlimited in communicating simple as well as complex silent messages to large numbers of personnel throughout their offices.

If your staff consists of 5 or more members and you have a need to communicate to 5 to 200 locations, you owe it to your practice to learn more about the amazing Digit-Up® System.

digit up®

Interested? Please write for a free brochure or call:
FL 1-904-726-4303
USA 1-800-344-4887

Please send me more information on the DIGIT-UP® communication system.

Name: _____ Zip _____

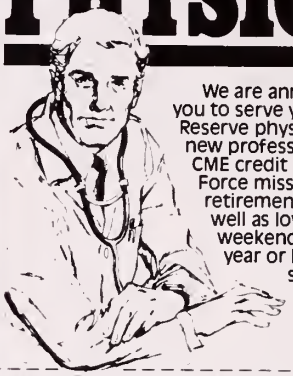
Address: _____ Locations: #

Phone: _____ Satff Members: # _____

RETURN TO DIGIT-UP® CORPORATION
Post Office Box 957
Floral City, FL 32636

OR CALL FL 1-904-726-4303
USA 1-800-Digit Up

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HO 10 AF/RSH
Bergstrom AFB, TX 78743-6002

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Prior Service? Yes ___ No ___

Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE

THE DADE COUNTY MEDICAL ASSOCIATION SPONSORS

MEDICAL EXPO '86

- Physicians
- Administrators
- Purchasing Agents
- Nurses
- Technicians
- Medical Managers

JOIN US FOR THE OPPORTUNITY TO SEE TOMORROW'S HEALTH CARE TODAY
NO ADMISSION CHARGE

DCMA WILL HOLD ITS QUARTERLY MEMBERSHIP MEETING AT EXPO

6:00 P.M.-RECEPTION/COMPLIMENTARY HORS D'OEUVRES 7:00 P.M.-PROGRAM

OVER ONE HUNDRED EXHIBITS FEATURING:

• PHARMACEUTICALS • LABORATORY SERVICES • MEDICAL EQUIPMENT & SUPPLIES •
• HEALTH CARE SERVICES • DIAGNOSTIC EQUIPMENT • HOSPITAL EQUIPMENT •
• COMPUTERS/SOFTWARE • INSURANCE • INVESTMENT COUNSELING •

ACCREDITED SEMINARS

GUEST SPEAKERS

SEPTEMBER 2, 1986 — 11:30 A.M.-9:30 P.M.
MIAMI EXPO/CENTER — MIAMI, FL
* FREE PARKING *

FOR INFORMATION CALL 1-800-225-4342 (Out of State)
or (305) 393-9199 (In Fla.)

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 473
- ☐ DEAN'S MESSAGE, 474
- ☐ ENCORES!, 475
- ☐ CORRECTION, 479

NOTES & NEWS

FMA testifies on delay in Medicare reimbursement

William J. Garoni, M.D., Chairman of the FMA Committee on Health Care Alternative Delivery Systems, testified before Senator Lawton Chiles on May 23, in Jacksonville, regarding the Medicare contractor delays in processing Medicare Part "B" claims. FMA has received numerous complaints from physicians around the state on the tremendous delays that Medicare has caused in reimbursing physicians for Medicare claims. In his testimony, Dr. Garoni stated that Congress has tried to encourage physicians to accept assignment and to participate in the Medicare program by providing quicker turnaround in claims paid. He went on to state that the recent delays in claims processing the physicians have encountered will encourage physicians not to participate in the program. Dr. Garoni gave several examples of physicians in the state who have actually had to take out bank loans to keep their practice operating due to the tremendous delay in turnaround time in Medicare claims processing. Dr. Garoni went on to state that the FMA strongly objects to the deliberate Medicare policy to delay payments at the expense of Medicare beneficiaries and providers of service under the Medicare program. Other participants that testified before Senator Chiles included officials of Blue Cross/Blue Shield of Florida, Inc., who stated unless they receive additional funding from the Health Care Financing Administration (HCFA), the average processing and payment time could be increased to 40 days by the end of September. As a result of this hearing, HCFA announced Friday that it was releasing another $750,000 in funding to Blue Cross and Blue Shield of Florida, Inc. Blue Cross and Blue Shield of Florida, Inc., commented that the added funds would allow the processing of about 500,000 more claims during the fiscal year.

Bill Long, Director of Government Programs of Blue Cross and Blue Shield of Florida, Inc., stated that increased federal regulations on how claims are processed are also contributing to the delay in processing claims. Other individuals who testified before Senator Chiles included senior citizens from the Jacksonville area who have experienced delays in claims reimbursement and the Regional Administrator from the HCFA out of Atlanta.

Southern Health Association Annual Educational Conference

The Southern Health Association, representing 16 southern states, is holding its annual educational conference in conjunction with the annual convention of the Florida Public Health Association in Palm Beach Gardens at the PGA Sheraton, June 24-27. The President of the Southern Health Association is J. Carroll Chambers, M.D., county health officer for Charleston, South Carolina. The President-Elect of the Florida Public Health Association is Robert Wilson, M.D., Director of the Escambia County Public Health Unit.

On June 24, from 9:00 a.m. to 4:30 p.m., the Southern Health Association will begin the conference with the Ira L. Myers Seminar for Physicians. This seminar, named for Ira Myers, M.D., Alabama's State Health Officer for the last 23 years who retired in May of this year, is being joint-sponsored by the Florida Medical Foundation for continuing medical education credits. CME credits (six hours, AMA Category I) will be awarded by the Florida Medical Foundation to physicians attending the seminar. No special registration will be charged for this seminar. However, participants will be limited to physicians registering for the joint annual educational conference. Seminar agenda topics include: Management of Common Infectious Diseases of Infants and Children; Infections in the Immuno-Suppressed Patient; the Place or Oral Hypoglycemic Agents in Diabetes Treatment; the Relationship between Diabetes Control and Complications; the Prevention, Diagnosis, and Treatment of Infections in the Elderly; and Acquired Immune Deficiency Syndrome.

Pfizer Hospital Products Group announces grant for innovation

Pfizer Hospital Products Group has announced a $50,000 research grant for an original invention in the medical device area.

A spokesman for Pfizer Hospital Products Group said those applying for the grant should be professionals active in one of the branches in the health care

field. The submitted proposal will be evaluated by an outside panel of experts. Influencing the decision will be the scientific merit of the invention, and its benefit to the patient, the company said. Consideration will be given to the practical application of the invention and its possible impact on the quality of health care.

Applications will be held in confidence and must be received no later than December 15, 1986. Materials can be ordered by writing to George Flouty, M.D., Pfizer Hospital Products Group, Research Grant for Innovation, Pfizer, Inc., 235 East 42nd Street, New York, New York 10017.

DEAN'S MESSAGE

Teaching the socioeconomics of medicine

Phillip Hampton, M.D., one of the senior internists in Tampa, has on his office wall a bill which his grandfather, also a Tampa practitioner, sent for an office visit in 1907.[1] The charge was one dollar. That bill, for one dollar, has been a good place to begin a discussion of the socioeconomics of medicine with students or house staff, because an office visit is one of the basic units of measurement for medical care. In 1913, the first year for which such numbers have been calculated, the consumer price index was 29.4. The current figure is about 325, which in approximate terms means that this limited office visit was worth about eleven of today's dollars.[2] A limited visit to a family practitioner in our clinic costs $35 — less of an increase over 50 years than most of us might have thought and hardly enough to cause the crisis in health care costs we hear so much about today. In fact, it is the rate of change which feeds the perception of crisis. The base (100%) year for the CPI was 1967. The first 60 years of inflation following Dr. Hampton's bill accounted for 240% increase of the inflation and the last 20 years for 665%. It is in these last 20 years that health care costs have moved aggressively ahead of inflation.

The problem with teaching the socioeconomics of medicine rests with deciding what else to include. Its meaning and content vary with the concerned constituency. For some it is cost containment. Others focus on cost effective care, almost but not quite the same as cost containment. Maximizing revenue (success), marketing (survival), indigent care (humanitarianism), distributing care (efficiency), controlling delivery of care (rationing) and a host of other topics have legitimate claim to representation in the socioeconomics of medicine.

The physician has an unusual, central, controlling role in the health care economy. It is not a role that most of us seek or enjoy. If anything must be taught, it is the understanding of this role. By any calculation — dollars from the individual or as a percentage of the gross national product — health care is expensive. The cost per illness has made an immense jump that exceeds the general inflation rate. Most of the increase in health care costs comes not from this physician's basic fee, but from the advances in health care that require more than a history and physical.

The year 1907 marked the first public showing of talking color motion pictures (Cleveland), the introduction of the first daily comic strip (Mr. Mutt, later Mutt and Jeff), the setting of the transatlantic speed record by the Lusitania (five days), and the admission of Oklahoma as the 46th state. X-rays were moving from being a curiosity to becoming a clinical tool[3] and Osler and McCrae published *Modern Medicine: Its Theory and Practice* in seven volumes. This was the dawn of modern times. A child born in the United States had a life expectancy of 50 years. The child of 1986 can expect 75+ years.[4] Much of that 25 year increment is ascribable to advances used by the physician, but provided outside of the context of the office visit.

The physician may or may not derive financial benefit directly from these services, but clearly he controls the access to them. It is a gatekeeper function. The integrity of the gatekeeper is often tested. The testing is innocent, and not a bribe. It is the result of the implementation by each side of a different code of ethical behavior: the medical ethic for one, the business ethic for the other.

Dr. Fredrick R. Abrams in a Commentary in the *JAMA* has found a workable definition of the two ethical codes.[5] "The medical ethic is to relieve suffering, to prolong life (when the patient judges this to be his desire), and to make each individual physically able to pursue happiness in whatever socially acceptable way he desires" and "the business ethic is to maximize the return on investment without breaking the law." Most of the services are provided in the context of the business ethic. One suspects that much of the interest from outside of medical schools about what socioeconomics we are teaching masks a desire that we identify this dichotomy and reconfirm that the gatekeepers are committed to the medical ethic.

Yankee magazine recently published extracts from a series of interviews with Arnold Relman, M.D., the editor of *The New England Journal of Medicine.*[6] Included were several of his "prescriptions for the future." These are much blunter statements affirming the physician's commitment to the medical ethic. To "the American Medical Association (AMA) and its member physicians: Adopt a stronger conflict-of-

interest policy banning investments in facilities to which physicians refer their own patients." To "trustees of voluntary hospitals: Avoid business arrangements with medical staff. Exert their influence as community leaders on behalf of the voluntary hospital system, especially in regard to the care of the poor. Put the public interest first, even ahead of the survival of the hospital, in considering questions such as the purchase of expensive new equipment, permitting expensive new surgical procedures, and mergers with other hospitals." Dr. Relman hopes to bind hospital trustees as well as physicians to the medical ethic.

In an address at the University of Minnesota in 1892,[7] Osler cautioned the students, "Always seek your own interests, make of a high and sacred calling a sordid business, regard fellow creatures as so many tools of trade, and, if your heart's desire is for riches, they may be yours; but you will have bartered away the birthright of a noble heritage, traduced the physician's well deserved title of the Friend of Man, and falsified the best traditions of an ancient and honorable guild." The integrity afforded by the medical ethic is not a new solution to the socio-economic problem associated with medical care. It just has never been easy to teach its application.

References

1. Personal Communication from Phillip Hampton, M.D.
2. Personal Communication from Dr. Don Bellante, Chairman of the Department of Economics, College of Business Administration, University of South Florida, Tampa.
3. Howell, Joel D.: Early Use of X-Ray Machines and Electrocardiographs at the Pennsylvania Hospital, 1897 through 1927. JAMA, 255(17):2320-2323.
4. National Center for Health Statistics, Department of Health and Human Services.
5. Abrams, Frederick R.: Caring for the Sick, An Emerging Industrial By-Product. JAMA, 255(7):937-938.
6. Clark, Tim: Confessions of a Worried Doctor. Yankee, February 1986, p. 84-87.
7. Osler, W.: Teacher and Student. In: Acquanimitas with other Addresses. 3rd ed. Philadelphia: Blakiston. 1932:40-1.

William A. Sodeman Jr., M.D.
Deputy Dean for Academic Affairs
University of South Florida
College of Medicine

ENCORES!

Lunar madness

Call me paranoid (go ahead, this is going to be a column on psychiatry anyway), but when I hear a group of doctors talking about women's menstrual cycles, my eyes still begin to narrow.

I am a member of "the curse" generation, you see, I remember when girls were excused from gym and women were kept out of public life because of that "time of the month." I remember when Hubert Humphrey's doctor said that no woman should be president because of "raging, hormonal imbalance."

So I was not entirely comfortable when the topic reappeared a few years ago, under the trendy title, Pre-Menstrual Syndrome. The good news was that male television anchors learned to say the word "menstruation" without stammering. The bad news was that some of the PMS talk sounded a lot like Humphrey's doc.

In three separate murder trials in England, Dr. Katherine Dalton testified that PMS had turned the defendant into "a raging animal each month." In TV land's "St. Elsewhere" a woman hospitalized with PMS attacked a nurse and screamed into millions of living rooms "I'm a danger to everybody!" PMS clinics sprung up around the country nearly as quickly as diet clinics and there are some that give out vitamins and even progesterone as blithely as they once gave out diet pills.

Now the curse, or the pre-curse, has struck again. Last week at the American Psychiatric Association's (APA) convention, the psychiatrists got into a controversy about whether to add "premenstrual dysphoric disorder," an extreme version of PMS, to the official list of mental disorders.

The psychiatrists divided loosely into two camps. Some insisted that labeling this as a mental disorder would do women more harm than good. Over the years, psychiatrists have diagnosed and treated more loony (as in lunar) women than men. This could be read as another message that women go crazy "that time of the month."

Others insisted that if there is a real problem out there, if there are patients in need of help, then you treat them without worrying about the political fallout. A disorder has to be listed in the profession's bible to get research funding, medical insurance, the money to study, treat and cure it.

Dr. Carol Nadelson, the outgoing president of the APA, put the problem succinctly: "On the one hand, you do not want to label anyone, or say that all women have raging hormonal symptoms. On the other hand, if you see people who are in trouble, you want to help them."

Despite my own PSS (Psychiatric Suspicion Syndrome), PMS is not a right-wing conspiracy or a fantasy of doctors in search of disease. It exists, as a little understood, highly individual combination of physical and psychological symptoms that varies enormously from one woman to another. Among some 5% of women, it deserves the capital S of Syndrome. Many fewer women are troubled enough emotionally to seek psychiatric help.

In the best of all possible worlds, a problem that affects such a small number of women should not threaten such a large number. In the best of all possible worlds, we would not attach a special stigma to any emotional problem, especially to one associated with the female anatomy. As Dr. Nadelson says, " I

wish that having a mental disorder were like having asthma.'' But it is not.

The APA controversy may end in a compromise position, in a special appendix on ''premenstrual dysphoric disorder'' added to the manual. But if PMS has a physical origin, I would rather see it listed under gynecology, not psychiatry.

We just are not all that far away from the raging hormonal-imbalance days. Even today, women and the female cycle are often regarded as ''abnormal.'' It is still by and large men who define normal, even while committing 90% of the crimes and waging nearly all the wars.

There are, unhappily, political statements that can come giftwrapped in medical diagnoses. The real world does not yet regard mental illness as asthma. The real world is all to happy to apply the newest ''crazy lady'' label.

Have you read the latest about Lizzie Borden, Sylvia Plath and Queen Victoria? Some researchers say they all suffered from PMS.

Ellen Goodman

Reprinted with permission of the *Washington Post* Writer's Group, Copyright 1986.

We need doctors we can pay less and boss more — namely, women

The striking increase in the number of women physicians in America may be the answer to the accusations that doctors are arrogant, exclusivist and selfish and that medical care has become too expensive. In fact, a profession made up largely of women may be exactly what is necessary to provide the kind of health-care system that the government and the public seem to be clamoring for.

Last fall, according to the Association of American Medical Colleges, 33.9% of those entering medical school were women. In 1969, the figure was 9.1%. In some schools, the percentage of women medical graduates will soon approach 50%.

This is happening at the same time as the legal crisis in which three out of four doctors can now expect to be sued for malpractice during their professional lives. Doctors who entered the profession in simpler times when neither their fees nor advice was questioned are increasingly asking themselves why they should continue to expose themselves to litigious patients. These older doctors — almost by definition male — are wondering why they should not simply retire and devote their time to managing their investments or other interests.

Meanwhile, I think I detect that students entering medical schools today differ markedly in their personality and motivation from those of a few years ago. Put at its baldest, the profession seems less attractive to individuals — men or women — who possess a strongly independent or entrepreneurial streak. With few exceptions, the medical students I come into contact with look forward to practicing in a group, or working as members of a prepaid health plan or as a salaried employee of a large health-care corporation. In such circumstances, they have all their overhead, insurance and fees taken care of. And they can make, on average, as much as $90,000 a year.

The implication of these changes is that medicine will shift in the next decade from a male-dominated profession towards a female-dominated profession, and this might be a very good thing.

For instance, medical costs can be more easily controlled as additional women enter the profession. Some authorities believe that as few as 25% of doctors will be solo practitioners by the year 2000. Others estimate that by the end of the century, 50% or more of the nation's physicians will be working at straight salary. These preferences make especially good sense for women in light of the desire of many to have time off for families. In a group practice, such arrangements are easily made. In a solo practice, however, time off with one's family is much more difficult to manage.

On the whole, this preference for salaried over private practice will keep health-care costs down. This is because, in general, a doctor stands to make more money in solo private practice than in any other arrangement. Further, this reduction in income will not have the devastating effect on women doctors that it would on their male counterparts. Most married women physicians I know have husbands who are professionals of one type or another and who earn respectable incomes. The traditional ''doctor marries nurse'' arrangement, it turns out, is extremely rare when the doctor happens to be the woman. Women doctors, as with professional women in general in our society, tend to ''marry up.''

More important than income, however, is autonomy. Traditionally, doctors have set their own hours, determined what patients they will see and when they will see them and within limits, even what they will charge. A physician of the recent past ruled his fiefdom with near-total autonomy. But all of that must be changed if our health-care system is to be more responsive. The emphasis is now on molding physicians who are flexible, cooperative, capable of understanding and working with group process and labor-management arbitration (There are now more than 10,000 physicians who have joined labor unions.).

Female physicians have an advantage over their male counterparts in adapting to this lessening of power and authority. This is not something that the health-care profession should be proud of, but it is a fact nonetheless: traditionally, women within the health profession (primarily nurses) were trained for docility and the taking of orders from superiors

(primarily doctors and other nurses). These female health-care workers did not expect to make a great deal of money nor garner much prestige. A similar situation is developing for women doctors.

As in all other professions in the society, female physicians can be expected to earn less than their male counterparts, on average. And because women doctors are more likely to practice in a group or clinic, their autonomy is limited in regard to such things as how much they will earn, how long and hard they will work, and how much time they will take off.

Of course, there are benefits to be gained by the entrance of more women into medical careers. For one thing, patients will benefit from an increase in humanism within the profession. This is not to say that all male doctors lack compassion. In general, however, I have observed that a woman doctor is more sensitive to a patient's anxieties and fears. She is also more capable of acknowledging and dealing with her patients' emotions.

If you combine a woman physician's natural intuitional and emotional assets with her willingness to work for less income and her willingness to settle for less autonomy, health-care planners are provided with a means to achieve several important goals.

- Health-care costs can be lowered, since doctors will be earning less.
- Medical care will be more readily accessible. Women doctors will work according to schedules convenient to the patient.
- Most importantly, physicians — both women and the dwindling number of men for whom the profession remains attractive — will be transformed from independent entrepreneurs into, simply, salaried bureaucrats. Such an arrangement has tremendous "management" advantages in the event of conflict between doctor and patient or doctor and employer. The "unruly" physician can be managed the same way one manages any other bureaucrat who steps out of line: write to the boss, register a complaint, get her fired or, at the very least, soundly chastised. No longer will it be necessary to deal with "arrogant" physicians or the "unresponsive" medical societies.

Ironically, many of the directors and officers (more often than not, males) of the corporations who will be employing female physicians possess the skills and attitudes that, a decade or two ago, would have attracted them to a medical career. They want to be on the cutting edge of new and exciting ventures. They want to feel important. They want to earn a lot of money. They want, in short, to be independent, pioneering, wealthy and influential — goals that not too many years ago most physicians set out in search of. But now all of that must be changed as we develop a new health-care system.

Nothing less is required than a remolding of the collective psyches of those who enter the profession. There is no longer a place within American medicine for the Ben Caseys of the world. Individuality and independence — often in the past combined with a measure of arrogance and a dash of the temperamental — must be replaced with a mindset that values cooperativeness and malleability, traits that, feminists' claims notwithstanding, come more easily to women than to men.

An increase in the number of women doctors can reasonably be expected to provide for additional role models who can facilitate the entrance into the profession of even more women. As the numbers increase, so too should the benefits of even cheaper and more available medical care. With this influx of women into medicine we can probably expect within not too many years a female-to-male ratio among doctors such as one finds in, say, Russia.

Will there eventually be a point of diminishing returns in all this? I do not think so. In fact, it is possible that within a decade the typical American doctor will be similar to a nurse in terms of income, power and autonomy.

Indeed, if we are serious about our desire for more compassionate and cheaper medical care along with a compliant and easily regulated medical profession, then we could hardly improve on present trends. If anything, what is needed are even more women doctors.

Richard Restak, M.D.
Washington, D.C.

Reprinted with permission from *The Washington Post National Weekly Edition*, May 26, 1986, page 25.

When to treat mild hypertension

Much has been written in the past five years about an apparent controversy over the treatment of hypertension. Some believe that patients whose diastolic pressure falls between 90 and 104 mm Hg (mild hypertension) should not be treated; an equally vocal group of experts believes that these patients should be treated.

When this furor erupted, I suggested a moratorium on editorial advocacy until the publication of new information, which would permit physicians to arrive at some meaningful decisions. Unfortunately, while waiting, we have seen editorial after editorial citing the same oft-quoted, already published reports of clinical trials. We have also witnessed academic rhetorical matches: whoever is most entertaining and appealing in major meetings or journals seems to prevail. Indeed, some physicians have suggested to me that "truth squads" should follow medical spokespersons in order to "straighten out" the situation.

Since there has been no moratorium and since a rational approach is possible on the basis of published information, I have decided to accept this opportunity to contribute once again my thoughts on when to treat the patient with mild hypertension. I believe that retrospective as well as prospective epidemiologic studies demonstrate that the higher the systolic or diastolic arterial pressures, the greater the morbidity and mortality. Prospective clinical trials from the VA, the Public Health Service, the Hypertension Detection and Follow-Up Program, the Multiple Risk Factor Intervention Trial, the European Working Party, Australia, Oslo, and other groups all demonstrated that control of arterial pressure is associated with significantly reduced mobidity and mortality. This has been shown in all patients whose pretreatment diastolic pressure remained persistently above 95 mm Hg. Where, then, does the controversy reside? It concerns the large subgroup of patients whose diastolic pressure falls between 90 and 94 mm Hg.

Arguments have been raised that with placebo therapy in Australia, diastolic pressure in some patients with mild hypertension may fall spontaneously below 95 mm Hg. For this reason, it was argued that these patients should not be treated. A reasonable approach has been suggested in the Joint National Committee's third (1984) report. Patients whose diastolic pressure is in the range of 90 through 94 mm Hg should be observed carefully while being managed with nonpharmacological modalities, including weight reduction, sodium restriction, restriction of excess alcohol intake, and even cessation of smoking. If pressure is not controlled, pharmacological therapy might be introduced. This reasonable course of action has been questioned for a variety of reasons: 1) side effects of pharmacological therapy might present a greater risk than that of pressure elevation; 2) other nations in the westernized world still pursue the recommendations to treat only when the diastolic pressure remains above 95 mm Hg; and 3) the major risk of hypertension is the development of coronary heart disease, and antihypertensive drug treatment has not been shown to affect the incidence of coronary disease and myocardial infarction.

In response to these points, it is appropriate to state that no matter which form of antihypertensive therapy is utilized, pressure reduction has been shown to reduce morbidity and mortality, whether the agents used have been diuretics, beta-blocking drugs, or other agents combined with either of these two classes of drugs. In addition, the broad variety of therapeutic options other than diuretics or beta blockers may involve fewer side effects. Furthermore, data from the United States, unlike those from other westernized societies, reveal a reduced overall cardiovascular morbidity and mortality during the past decade. Perhaps the more vigorous approach to antihypertensive therapy by U.S. physicians, in response to the advice of the High Blood Pressure Education Program, may explain some of the reductions. Clearly, the referred-cared physicians of the Hypertension Detection and Follow-Up Program reduced average diastolic pressures to levels below 90 mm Hg in patients with mild hypertension.

A different line of reasoning, however, may explain why myocardial infarction has not been reduced in most of these prospective clinical trials. Most of the studies were undertaken in smaller groups of patients (Veterans Administraton, Public Health Service) whose average age at study entry was in the mid-40s. Data from postmortem examinations of healthy 18-year-old U.S. soldiers in Korea and Vietnam clearly show that early atherosclerotic coronary heart disease exists even in the late teen years. Recent data from the Bogalusa Heart Study confirmed that fatty streaks and excessive low density lipoprotein cholesterol (highly correlated with one another) were demonstrable in healthy young persons whose mean age was 18 years and who died accidentally. One then wonders how a prospective clinical trial conducted over as short a time as five years in a few hundred subjects would reverse the course of a progressive second disease process such as atherosclerosis. Nonetheless, the data for patients with mild hypertension in the Hypertension Detection and Follow-Up Program and for the elderly patients of the European Working Party study strongly suggest that antihypertensive therapy did, in fact, affect the course of coronary heart disease.

In the light of these reports, and despite opinions to the contrary, patients with mild hypertension deserve close follow-up and management of their blood pressure. It is my personal recommendation that the following course of action be undertaken.

1. If diastolic pressure remains in excess of 90 mm Hg on three different visits to a physician's office, nonpharmacological treatment should be prescribed.
2. If the diastolic pressure remains at 95 or above, drugs should be instituted, preferably in submaximal doses on a once-daily basis with attention paid to side effects, contraindications, and other clinical findings in that individual.
3. If diastolic pressure remains between 90 and 94 mm Hg, nonpharmacological therapy may be continued with observation somewhat longer, bearing in mind that those patients who are at greater risk (older patients, black patients, and those with a strong family history of cardiovascular complications or premature death) should be treated earlier with antihypertensive agents. I would also identify those individuals with high normal pressures (85 to 89 diastolic) and would follow them at more frequent intervals, recommending nonpharmacological maneuvers because their diastolic pressures are more likely to rise to mild hypertensive levels.

In any event, I strongly believe that patients with mild hypertension will benefit from treatment; they

should not be neglected, controversy notwithstanding. Five-year mortality for the untreated is significantly greater than for the actively treated. True, only a percentage of patients may benefit, but for individuals who may die, or sustain severe disability, their personal rate of incidence would be 100%!

Edward D. Frolich
Alton Ochsner Distinguished Scientist and Vice President for Academic-Affairs
Alton Ochsner Medical Foundation
New Orleans, LA

Reprinted with permission from *Hospital Practice*, May 30, 1986, page 9.

CORRECTION

Posttransfusion purpura — a rare manifestation of blood transfusion

The following chart should have appeared in the May issue, Vol. 73, No. 5, page 383, with the article "Posttransfusion purpura — a rare manifestation of blood transfusion," by Muhammad Saeed, M.D., F.A.G.S., and Charles E. Barrineau, M.D., F.A.C.S.

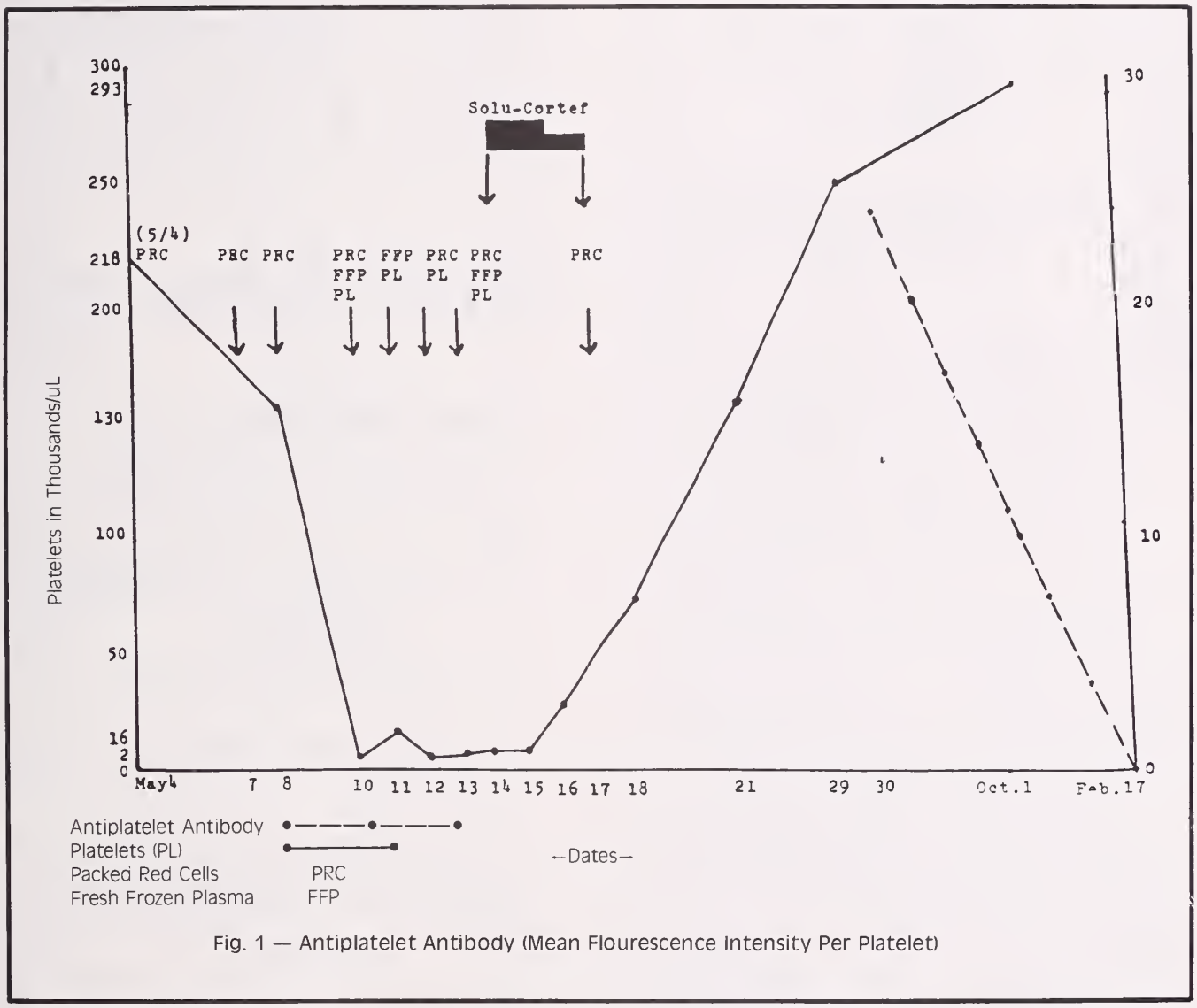


Fig. 1 — Antiplatelet Antibody (Mean Flourescence Intensity Per Platelet)

AN INVESTMENT IN MEDICALLY RELATED REAL ESTATE

Announcing

RWB MEDICAL INCOME PROPERTIES 1 LIMITED PARTNERSHIP

A $25,000,000 public real estate limited partnership.

A newly organized public real estate limited partnership designed to provide investors the opportunity to participate in the ownership of a diversified portfolio of income-producing medically related real estate. The minimum investment is $5,000; $2,000 for IRA, Keogh and pension plans in most states.

Buchanan & Co., Inc.
10006 North Dale Mabry, Suite 213
Tampa, Florida 33618 Attn. Kim Wright
(813) 961-8168 1-800-282-2010

☐ Yes, I would like to learn more about RWB Medical Income Properties 1 Limited Partnership. Please send me a Prospectus at no obligation.

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

HOME PHONE (___) _____ BUS. PHONE (___) _____

This announcement is neither an offer to sell nor a solicitation of offers to buy any of these securities. The offer is being made only by the Prospectus.

BIG BULL ELK and TROPHY SIZE TROUT in a WILDERNESS SETTING



Quality.

We've been building it into our outdoor recreation program for more than 30 years.

Luxurious accommodations, exquisite cuisine, and a 32,000 acre private mountain ranch is your up-front guarantee of an unforgettable holiday.



Enjoy unmatched trout fishing, hunt for elk, deer or bear, and then relax in comfort at our secluded lodge on the Colorado-New Mexico border.

Please direct inquiries to:
Leo Smith, Manager
Chama Land & Cattle Company
P.O. Box 746G, Chama, NM 87520
(505) 756-2133.

CHAMA
LAND & CATTLE COMPANY
Chama, New Mexico

Bryant Bureau

The Recruiting and Placement Specialists

Physician Staffing Needs Full Time or Locum Tenum

The Best Source for Qualified Physicians in Florida

Suite 308, Colonial Bldg., 16201 S.W. 95th Ave.,
Miami, Fla. 33157 (305) 252-1949

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

Thirteenth Annual Review Course for
Certification in Internal Medicine

"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"

August 17-30, 1986
Key Biscayne Hotel and Villas, Key Biscayne
Director: J. Maxwell McKenzie, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for certification in Internal Medicine. It will provide an intensive and comprehensive survey of those aspects of Internal Medicine which should be familiar to internists qualified for certification and recertification. Printed materials with references and self-assessment questionnaires will be provided to all registrants. This course will end ten days prior to the certification examination of the American Board of Internal Medicine.

A faculty especially selected for its expertise in review courses will present the following topics:

Week I	Week II
Cardiology	Infectious Diseases-Immunololgy
Pulmonary	Nuclear Medicine-Oncology-Genetics
Toxicology-Hypertension-Hepatology	Endocrinology
Renal-Acid Base	Gastroenterology
Rheumatology	Ophthalmology-Critical Care-Dermatology Laboratory
Hematology	Radiology-Neurology-Psychiatry

Highlights

State of the Art Lectures	88 credit hours in Category I
Patient Managment Problems	Self-Assessment Questionnaire Sessions
Pictorial Quizzes	Videotape Symposiums
Syllabuses	Audio-Visual Aids
Meet the Faculty Sessions	

Registration: Entire Course (August 17-30) $750 (before 5/31)
$800 (after 5/31)
Week I (August 17-23) $550
Week II (August 25-30) $550

Includes tuition, printed materials, use of audiovisual aids, library loan of T.V., tapes, cassette tapes and set of slides.

For registration and information write to:
J. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101 Telephone: (305)547-6063



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.
Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

YOUR NEW LOW DAILY RATES AT AVIS START AT $33.00



Avis features GM cars. Buick Century.

Your association membership means new, uniform low flat rates at Avis. And there's no charge for mileage. Choose from subcompact through full size 4-door car groups:

DAILY RATE	
SUBCOMPACT (Chevrolet Chevette or similar)	**$33.00**
FULL SIZE 2-DOOR (Buick Century or similar)	**$39.00**

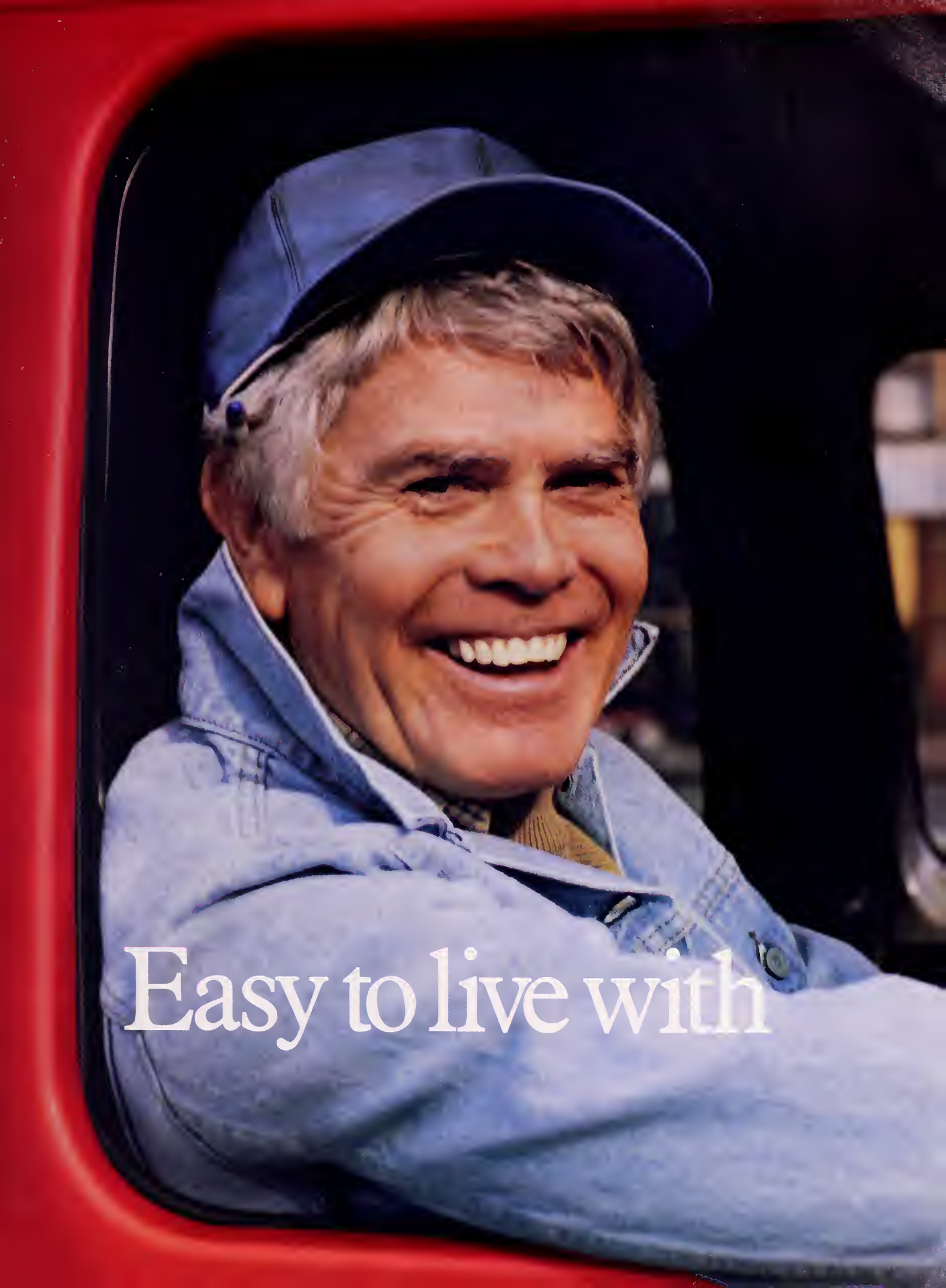
These uniform low flat rates make it easy to know your rate before you go. To reserve a car, call Avis toll free: ***1-800-331-1212***

Be sure to mention your Avis Worldwide Discount number: **A/A616900.**

AVIS® ***WE TRY HARDER.®***

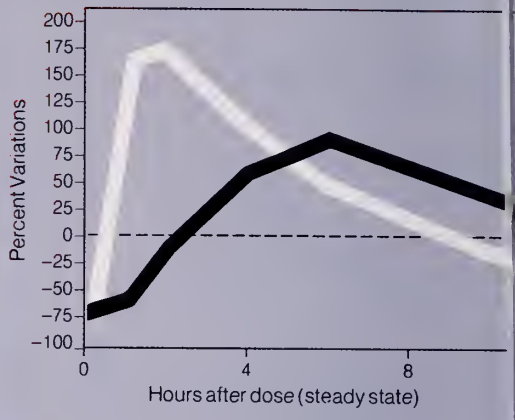
Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. Flat rates are nondiscountable and are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. An additional charge per day will apply in certain locations including Newark Airport, NJ; LaGuardia Airport, NY; Kennedy Airport, NY; and all Manhattan locations. Check with Avis for the amount. Rates, discounts and additional charges subject to change without notice. Cars must be returned to rental location or higher daily rate and a one-way service fee will apply. Cars and particular car groups subject to availability. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

© 1985 Avis Rent A Car System, Inc., Avis®


Easy to live with



INDERAL LA and



- INDERAL LA avoids the sharp peaks seen with atenolol

Blood pressure controlled,

Smooth blood pressure control and well tolerated

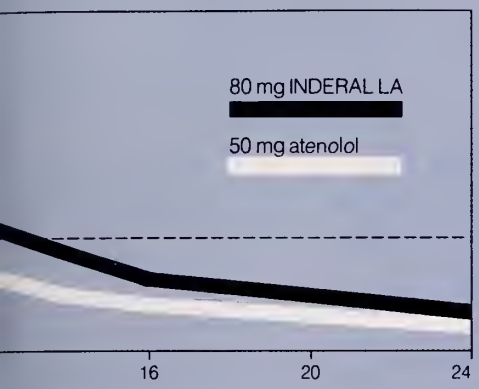
Once-daily INDERAL LA (propranolol HCl) keeps life simple for the patient. A single dose provides 24-hour blood pressure control. Convenient and well tolerated, INDERAL LA rarely interferes with everyday living. In fact, a recent study of 138 patients found a low incidence of side effects with INDERAL LA, which was not significantly different from that reported with metoprolol and atenolol.[2]

INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

Once-daily
INDERAL® LA
(PROPRANOLOL HCl) *Long Acting Capsules*

Please turn page for brief summary of prescribing information.

atenolol over 24 hours*[1]



*Plasma concentrations in relation to the mean.

- Smooth, consistent plasma drug levels over 24 hours
- Full, 24-hour blood pressure control with INDERAL LA



and feeling good.

Added blood pressure control with the preferred diuretic

When more than one antihypertensive agent is needed, once-daily INDERIDE LA enhances patient compliance to improve long-term control. Patients receive all the benefits of controlled-release INDERAL LA *and* standard-release hydrochlorothiazide (HCTZ), for comfortable morning diuresis. Not only does this regimen permit patients to follow normal daily routines, but HCTZ also produces less potassium wastage on a mg-for-mg basis than chlorthalidone.[3,4]

Once-daily

INDERIDE® LA

(PROPRANOLOL HCl (INDERAL® LA) /HYDROCHLOROTHIAZIDE)

As with all fixed-combination antihypertensives, INDERIDE LA is not indicated for the initial treatment of hypertension.

Please turn page for brief summary of prescribing information.

Once-daily INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories

Once-daily INDERIDE® LA

Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg



The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS)*

INDERAL® LA Brand of PROPRANOLOL HYDROCHLORIDE **(Long Acting Capsules)**
INDERIDE®LA Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE **(Long Acting Capsules)**

INDERAL LA AND INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs, such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18 month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY: Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS: Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss; emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes; dry eyes, male impotence; and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia; gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis; sialadenitis.

Central Nervous System: Dizziness, vertigo; paresthesias; headache; xanthopsia.

Hematologic: Leukopenia, agranulocytosis; thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash; urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis); fever; respiratory distress, including pneumonitis; anaphylactic reactions.

Other: Hyperglycemia; glycosuria; hyperuricemia, muscle spasm, weakness; restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES

1. Data on file, Ayerst Laboratories. **2.** Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321-1323. **3.** Sumiye L, Vivian AS, Frisof KB, et al: Potassium loss associated with hydrochlorothiazide versus chlorthalidone. *Clin Ther* 1981;4:308-320. **4.** Ram CVS, Garrett BN, Kaplan NM: Moderate sodium restriction and various diuretics in the treatment of hypertension. *Arch Intern Med* 1981;141:1015-1019.

5593/486

Ayerst AYERST LABORATORIES
New York, NY 10017

© 1986 Ayerst Laboratories

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

The march on Tallahassee

Preparing for the March on Tallahassee on April 21 made me feel a little like "the engine that could!" I thought we could organize and get the necessary turn-out, but a little voice inside me kept saying, "We can't, we can't!"

Under graying clouds, 70 hardy souls from Ocala loaded on two buses to make the three hour trip to Tallahassee. Those of us who identify with rising suns, chirping birds, and 6:45 a.m. were bouncing in our seats. Coffee and donuts helped others greet the morning with a semblance of civility.

By the time the Capitol was in view, the sun was shining and we were mentally armed for the political arena. We were met at the bus by a worker who herded us to our section of the Civic Center. We had our CAP 250 hats and our name tags within minutes.

Filing into the Civic Center Arena was the beginning of a roller coaster day. There we were! All 3,500 of us! Incredible! For once, it was not just doctors. Marion County brought representatives from many other fields. People were there with their children, their signs, and their hats!

Mrs. Milton Tignor, President of the Florida Medical Association Auxiliary led the singing of the National Anthem during the opening ceremonies. The speeches were short, but explosive! There were horror tales of liability settlements, most of which were not malpractice suits. The President of the Florida Realtors announced that they were joining us as the 76th member of the Coalition. Some speakers fortified our wills to win, while others cautioned us about acting in any way other than as ladies and gentlemen. Additional speeches solidified our feelings as to the righteousness of our cause.

The luncheon was another revelation. In one hour everyone enjoyed a delicious, hot meal served by the Civic Center staff. All the members of the Legislature had been invited to the luncheon. Many came and were greeted with enthusiasm by their constituents; the subject: tort reform.

Final instructions were given by the coalition leaders as the wide doors were rolled open. Out we poured, from curb to curb, three long blocks of color, signs, balloons, and CAP 250 hats. Reporters interviewed marchers as mini-cam operators scanned the crowds, and the sun glinted off camera lenses. As we marched along we just felt that this had to do some good!

The Capitol doors were the end of the signs and the balloons. Our county executive secretary tried to make appointments with our legislators, but could not get definite commitments. We went to their offices anyway. We tried to see them; then signed our names to their rosters so they knew we were there!

Before we could say "tort reform" it was 5:00 p.m. and time to catch the bus for home. Sitting in the seats relaxing with our sandwiches and refreshments which we had brought with us that morning, we started to feel let-down. Would it do any good? Would it be reported on the news as it had happened? Does anyone care? We do!

We did what we set out to do. We were able to get 76 different organizations representing 700,000 people to come together for one common cause: to express their consensus on one subject. Tomorrow we would worry about continuing the work of getting people to participate in "Days in the Legislature" and to work for the candidate of their choice. It is important to show that we care and that we are interested in seeing good tort reform.

Mrs. James (Rita) Seymore
Marion County Auxiliary President
Ocala

THE APPROPRIATE GIFT FOR
AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

City & State _____

Dr. _____

Street _____

City & State _____

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.,* P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

MILLIONS OF PEOPLE HAVE BEEN CURED OF A DISEASE MOST PEOPLE THINK IS INCURABLE.

We've made significant progress against most forms of cancer.

But, as far as many people are concerned, cancer is still a fatal disease.

There are nearly three million people who would disagree. People who have had cancer and are now cured.

For certain forms of cancer, the progress we've made is nothing short of miraculous.

With early detection and prompt treatment, the survival rate for Hodgkin's disease can be as high as 74%. Childhood leukemia: as high as 65%. Colon and rectal cancer: as high as 75%. Breast cancer: as high as 90%.

Today, one in every two people who get cancer will survive.

As far as we've come, we still have quite a way to go. And for that, we'd like your help.

There's only one place where cancer is a hopeless disease:

In your mind.

AMERICAN CANCER SOCIETY®

Help us keep winning.

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

JULY

ACLS Course, July 12-13, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Coronary Heart Disease, July 18-19, Dutch American Hotel, Orlando. For more information: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

Infections in the Immune Compromised Individual, July 19, Tradwinds Resort, St. Petersburg. Contact: Jack Hutto, M.D., (813) 898-7451.

MRI, CT & NM in Clinical Practice, July 21-25, Grand Hotel, Paris, France. Contact: Lawrence Muroff, M.D., USF College of Medicine, 12901 N. 3oth Street, Tampa 33612, (813) 873-2090.

Electrocardiography, July 24-27, Marco Beach Resort, Marco Island. Contact: Henry Marriott, M.D., 601 12th Street, North, St. Petersburg 33705.

Imaging Advances in Medicine, July 28-August 1, Churchill Hotel, London, England. Contact: Lawrence Muroff, USF College of Medicine, 12901 N. 30th Street, Tampa 33612, (813) 873-2090.

AUGUST

ACLS Course, August 1-3, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Second Annual Laser Surgery Training Course, August 12-16, Wyndham Hotel, Orlando. For more information: Patti Devlin, 1414 South Kuhel Avenue, Orlando 32806-2093, (305) 841-5144.

Basic Trauma Life Support, August 8-9, USF College of Medicine, Tampa. Contact: James Hillman, M.D., (813) 251-6911.

Second Annual Laser Surgery Training Course, August 12-16, Wyndham Hotel, Orlando. Contact: Patti Devlin, 1414 South Kuhl Ave., Orlando 32806-2093, (305) 841-5144.

Pediatric-Oriented Advanced Cardiac Life Support, August 22-24, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Strategic and Operational Survival Plans for Office Based Physicians, August 22-24, Orlando Hyatt Hotel, Orlando. For more information: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

ACLS Course (Pediatric), August 22-24, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Emergency Management of Facial, Hand and Soft Tissue Injuries, August 24-28, Ameilia Island Plantation, Amelia Island. Contact: Ira M. Dushoff, M.D., 580 West 8th Street, Jacksonville 32209, (904) 355-0561.

A Stitch in Time, August 24-28, Amelia Island Plantation Convention Center, Amelia Island. For more information: Ira M. Dushoff, M.D., 580 W. 8th Street, Jacksonville 32209, (904) 355-0561.

SEPTEMBER

Doppler Echocardiograph Seminar, September 11-13, Innisbrook Resort, Tarpon Springs. Contact: Ann Connelly, R.N., 300 South Hawthorne Road, Winston-Salem, NC 27103.

Aviation Medical Seminar — For Aviation Medical Examiners, September 18-21, Doral Hotel, Miami. Contact: James L. Harris, M.Ed., P.O. Box 25082, Oklahoma City, OK 73125, (405) 686-4881.

Pediatrics for the Practitioner, Sept. 19, Bay Harbor Inn, Tampa. Contact: Herbert H. Pomerance, M.D., USF Dept. of Pediatrics, 12901 N. 30th Street, Box 15CE, Tampa 33612, (813) 974-4214.

Pediatrics for the Practicing Physician, Sept. 19, 1986, Bay Harbour Inn, Tampa. Contact: H.H. Pomerance, M.D., (813) 974-4214.

Pediatrics for the Practitioner: Update in Hematology and Oncology, Sept. 19, Bay Harbour Inn, Tampa. Contact: H.H. Pomerance, M.D., USF Dept. of Pediatrics, 12901 N. 30th Street, Box 15CE, Tampa 33612, (813) 974-4214.

OCTOBER

Cardio Respiratory Disease, October 1-4, Marriott's Orlando World Center, Orlando. Contact: Patti Devlin — CME Coordinator, Orlando Regional Medical Center, 1414 S. Kuhl Avenue, Orlando 32806-2093, (305) 841-5144.

Fourth Annual Advanced Neuroradiology Seminar, October 9-11, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Fifth Annual Medical Laboratory Immunology Symposium, October 19-22, Holiday Inn Surfside, Clearwater. Contact: Herman Friedman, Ph.D., (813) 974-3281.

Arrhythmias: Interpretation, Diagnosis and Management, Oct. 24-25, Orlando Hyatt Hotel, Orlando. Contact: Deborah Wilderson, 5808 S. Rapp Street, #202, Littleton, CO 80120 (303) 798-9682.

NOVEMBER

Neonatal and Pediatric Respiratory Disease Conference, November 6-9, Holiday Inn Sufside, Clearwater Beach. Contact: R.L. Siegel, M.D., USF College of Medicine, 12901, N. 30th Street, Tampa 33612, (813) 972-3131.

Vascular and Pulmonary Diseases, December 5-6, 1986, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson, 5808 S. Rapp Street, -202, Littleton, CO 80120, (303) 798-9682.

Magnetic Resonance Imaging, December 8-12, 1986, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

International Conference on Hypertension in the Elderly, December 12-16, Wyndham Hotel Sea World, Orlando. Contact: Bruce Robinson, M.D., (813) 974-2460.

DECEMBER

Refinements in Gastroenterologic Diagnosis, December 3-5, 1986. Contemporary Hotel, Lake Buena Vista. Contact: H. Worth Boyce Jr., M.D., USF Medical Center, Box 19, 12901 N. 30th Street, Tampa, 33612, (813) 974-2034.

Workshop on Clinical Hypnosis, December 4-7, 1986, Tampa Hilton, Tampa. Contact: Alexander A. Levitan, M.D., 2051 Long Lake Road, New Brighton, Minnesota 55112, (612) 786-1620.

The American Diabetes Association through its service, education and research programs, gives help today and hope for tomorrow to all children and adults with diabetes. YOU can help support these projects by calling your local DIABETES ASSOCIATION, listed in your telephone directory.
CALL TODAY!

Florida Affiliate
(305) 894-6664

Motrin® 800 mg TABLETS
ibuprofen



Extra strength
Convenience
Economy

Upjohn
A Century of Caring
1886-1986

©1986 The Upjohn Company

J-6138 January 1986

"High blood pressure should be a red flag to screen for cholesterol..."[1]



Wyeth Laboratories
Philadelphia, PA 19101

If your patients have hypertension, they probably have high cholesterol too.

The Framingham Heart Study[2] showed that over two thirds of the 35 and older population in that study with systolic blood pressures over 145 mmHg also had serum cholesterol levels of 225 mg/dL or more, and 46% had levels above 250 mg/dL.

While many clinical laboratories still report 250 mg/dL as "normal" cholesterol, the NIH Consensus Development Conference Statement on Cholesterol and Heart Disease[3] stated that any level above 220 mg/dL is associated with a significantly increased risk of coronary heart disease.

You need to know, because high cholesterol parallels high blood pressure as a CHD risk factor.

Epidemiological studies and large-scale prevention trials have indicated that as with blood pressure, serum cholesterol levels are proportionately related to CHD risk.

Specifically, *"...for every 10 mmHg rise in pressure, there appears to be about a 30% rise in cardiovascular risk."*[4] *"...for every one percent you go up the American cholesterol scale, your subsequent rate of heart attack rises two to three percent."*[5]

And although the specific impact on CHD has not been determined, we know that many of the principal agents used to lower blood pressure actually increase cholesterol.

Wytensin® lowers blood pressure effectively without raising cholesterol.

While Wytensin is not a cholesterol-lowering agent and is not indicated for the treatment of hyperlipidemia, in controlled clinical trials[6] it caused a slight, sustained decrease in total cholesterol without reducing the HDL fraction or altering serum triglycerides.

At the same time, Wytensin lowered blood pressure as effectively as hydrochlorothiazide, propranolol, clonidine or methyldopa. Drowsiness and/or dry mouth, the most frequent side effects noted with Wytensin, usually diminish or disappear over time. In fact, in double-blind studies to date, discontinuance of therapy for all side effects occurred in about 13% of patients.

WyTensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol



See important information on following page.

References: 1. Glueck CJ: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 2. *The Framingham Study, An epidemiological investigation of cardiovascular disease*, Section 28, U.S. Dept. of Health, Education, and Welfare. 3. National Institutes of Health Consensus Development Conference Statement, 1984: Vol 5, No 7, p 4. 4. Chobanian AV: The influence of hypertension and other hemodynamic factors in atherogenesis. *Progress in Cardiovascular Diseases, XXVI* (3): 177, Nov/Dec, 1983. 5. Castelli WP: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 6. Data on file, Wyeth Laboratories.

© 1985, Wyeth Laboratories

Wytensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

Brief Summary

Before prescribing, consult the complete package circular.

Indications and Usage: Treatment of hypertension, alone or in combination with a thiazide diuretic

Contraindication: Known sensitivity to the drug

Precautions: 1 Sedation Causes sedation or drowsiness in a large fraction of patients When used with centrally active depressants, e g , phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects 2 Patients with vascular insufficiency Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure. 3 Rebound Sudden cessation of therapy with central alpha agonists like **Wytensin** may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology

INFORMATION FOR PATIENTS Advise patients on **Wytensin** to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy Warn patients that tolerance for alcohol and other CNS depressants may be diminished Advise patients not to discontinue therapy abruptly

LAB TESTS In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test During long-term use there was small decrease in serum cholesterol and total triglycerides without change in high-density lipoprotein fraction In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease

DRUG INTERACTIONS **Wytensin** was not demonstrated to cause drug interactions when given with other drugs, e g , digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antiinfective agents, in clinical trials However, potential for increased sedation when given concomitantly with CNS depressants should be noted

DRUG/LAB TEST INTERACTIONS No lab test abnormalities were identified with **Wytensin** use

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY No evidence of carcinogenic potential emerged in rats during a two-year oral study with **Wytensin** at up to 9 5 mg/kg/day, i e about 10 times maximum recommended human dose In the Salmonella microsome mutagenicity (Ames) test system, **Wytensin** at 200-500 mcg per plate or at 30-50 mcg/ml in suspension gave dose-related increases in number of mutants in one (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture In another eukaryotic system, *Saccharomyces cerevisiae*, **Wytensin** produced no activity in an assay measuring induction of repairable DNA damage Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9 6 mg/kg), suggesting impairment of fertility Fertility of treated males (9 6 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy

PREGNANCY Pregnancy Category C WYTENSIN® MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN A teratology study in mice indicated possible increase in skeletal abnormalities when **Wytensin** is given orally at doses 3 to 6 times maximum recommended human dose of 1 0 mg/kg These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits However, increased fetal loss has been observed after oral **Wytensin** given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg) Reproductive studies in rats have shown slightly decreased live-birth indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6 4 and 9 6 mg/kg There are no adequate, well-controlled studies in pregnant women **Wytensin** should be used during pregnancy only if potential benefit justifies potential risk to fetus

NURSING MOTHERS Because no information is available on **Wytensin** excretion in human milk, it should not be given to nursing mothers

PEDIATRIC USE Safety and effectiveness in children less than 12 years of age have not been demonstrated, use in this age group cannot be recommended

Adverse Reactions: Incidence of adverse effects was ascertained from controlled clinical studies in U S and is based on data from 859 patients on **Wytensin** for up to 3 years There is some evidence that side effects are dose-related Following table shows incidence of adverse effects in at least 5% of patients in study comparing **Wytensin** to placebo, at starting dose of 8 mg b i d

Adverse Effect	Placebo (%) n = 102	Wytensin (%) n = 109
Dry mouth	7	28
Drowsiness or sedation	12	39
Dizziness	7	17
Weakness	7	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20% Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less Cardiovascular—chest pain, edema, arrhythmias, palpitations Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort Central nervous system—anxiety, ataxia, depression, sleep disturbances ENT disorders—nasal congestion Eye disorders—blurring of vision Musculoskeletal—aches in extremities, muscle aches Respiratory—dyspnea Dermatologic—rash, pruritus Urogenital—urinary frequency, disturbances of sexual function Other—gynecomastia, taste disorders

Drug Abuse and Dependence: No dependence or abuse has been reported

Overdosage: Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic Vital signs and fluid balance should be carefully monitored Adequate airway should be maintained and, if indicated, assisted respiration instituted No data are available on **Wytensin** dialyzability

Dosage and Administration: Individualize dosage A starting dose of 4 mg b i d is recommended, whether used alone or with a thiazide diuretic Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response Maximum dose studied has been 32 mg b i d , but doses this high are rarely needed

How Supplied: (guanabenz acetate) Tablets, 4 mg, bottles of 100 and 500; 8 mg and 16 mg, bottles of 100

Revised 2/14/85

Wyeth Laboratories
Philadelphia Pa 19101

©1984, Wyeth Laboratories.

Ad Council

TWELVE IMPECCABLE EXCUSES FOR NOT GIVING BLOOD.

"1. I think I have lumbago.
2. I'm type Z negative.
3. I'm on the grapefruit diet.
4. I gave six months ago.
5. I just got back from Monaco.
6. The lines are thirteen blocks long.
7. My mother won't let me.
8. I didn't sign up.
9. I'm going out of town.
10. Asthma runs in my family.
11. I forgot to eat this morning.
12. I'm allergic to flowering magnolia."



Each one's a doozy, but we're hoping you won't use any of them. Give blood through the American Red Cross. Please, don't chicken out.

EXCUSES DON'T SAVE LIVES. BLOOD DOES.

American Red Cross

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

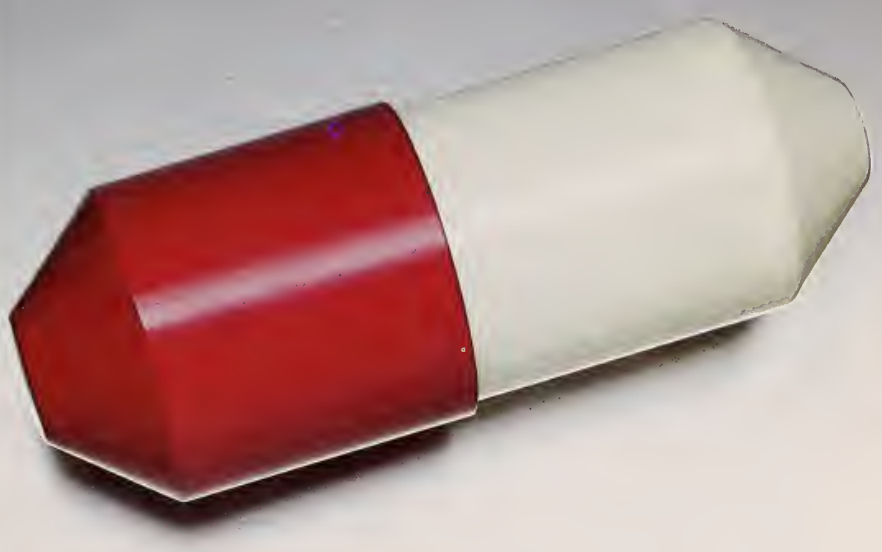
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L42

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions)



Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 19 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.



a product of

SK&F CO.

Carolina, P.R. 00630

©SK&F Co., 1983



To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
with acetaminophen 500 mg

Brief Summary

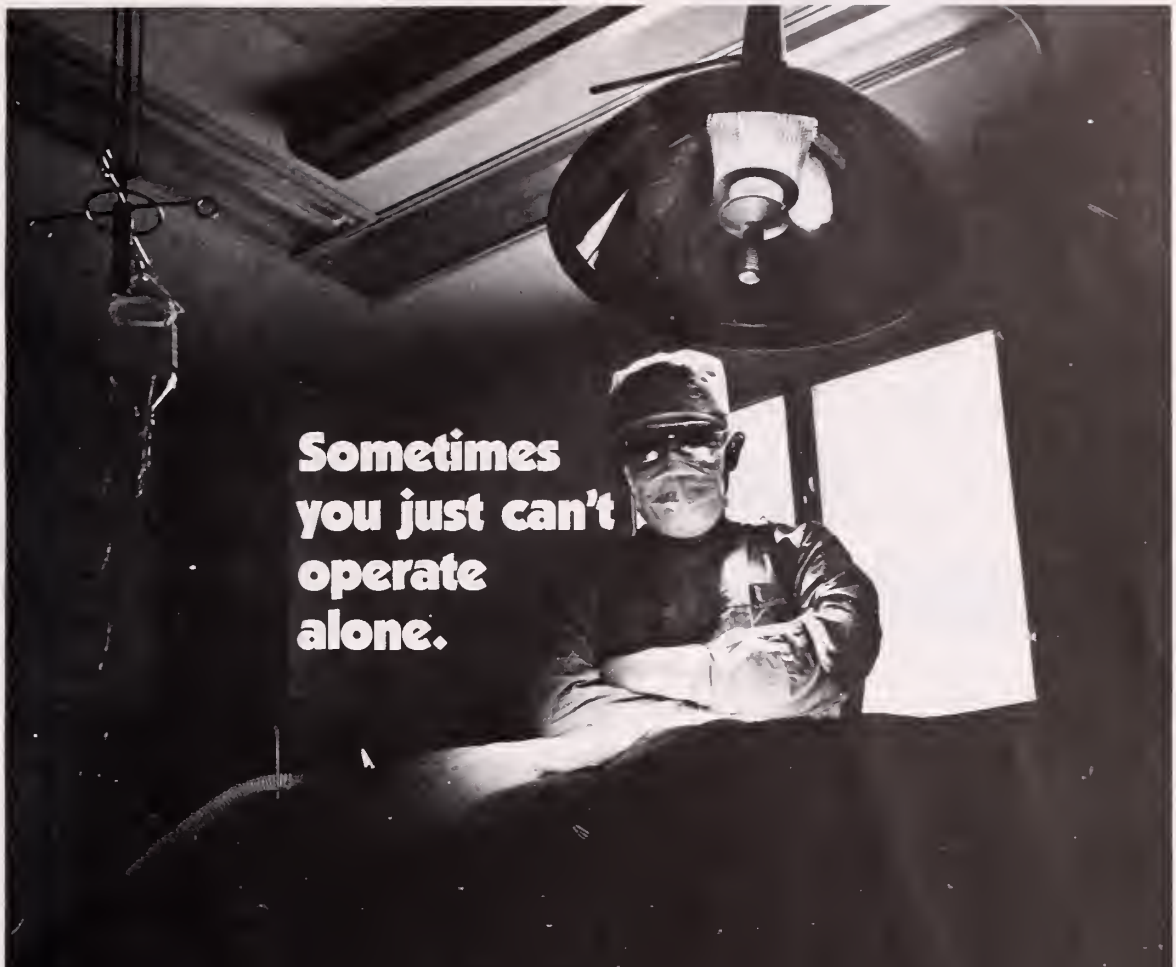
INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics, therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982

knoll® KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

5725

February, 1985



When it comes to saving lives, teamwork becomes not only desirable; it becomes necessary.

In an operating room, in an emergency room, in consultation with other physicians, teamwork helps you do your job to the best of your ability.

The American Medical Association and your state and county medical societies believe in the value of teamwork — and the necessity of it, in the face of an increasingly complex professional environment.

We also believe that medical societies have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

For example, to keep government regulations from interfering with your practice, we effectively represent your interests at local and national levels.

To influence policies of organized medicine with which you disagree, we provide the means to have your views heard and respected.

And to keep you up to date on the latest medical advances, we publish JAMA, AM News, specialty, state, and county journals.

In fact, for all the times you can't operate alone, your medical societies will be there. Working with you to defend your rights and protect your freedoms.

Join Your Medical Societies Today.

For more information, contact your county or state medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name _____

Street _____

City _____ State _____ Zip _____

County _____



Imagine waking up with painful stomach cramps.

Imagine going through your day with terrible diarrhea.

Now imagine those painful, embarrassing symptoms never going away.

That's what people with Ileitis and Ulcerative Colitis endure every day.

Over 2 million men, women and children suffer with these devastating intestinal diseases. That's more than Muscular Dystrophy and Cerebral Palsy combined.

Yet as widespread as Ileitis and Ulcerative Colitis are, they're just as misunderstood.

Some people think these diseases are only in your mind.

They're not.

Some people think they come from eating the wrong kinds of foods.

They don't.

Some people even laugh at the symptoms.

They shouldn't.

Because Ileitis and Ulcerative Colitis can strike at any age, at any time. And there's no known cause. Or cure.

If you can imagine yourself enduring this kind of pain, you know why we need your help.

And why we need it now.

The National Foundation for
Ileitis & Colitis

To send your tax-deductible contribution or for more information, please write: N.F.I.C., P.O. Box 2020, Murray Hill Station, New York, NY 10156

Government Printing Office Bookstore

Jacksonville, Florida

The Government Printing Office Bookstore in Jacksonville, Florida carries in stock the International Classification of Diseases, 9th edition (ICD-9). This three-volume set contains the codes used in filing insurance claims. Price: $29.00 (paper edition) and $40.00 (cloth edition).

The book store also carries in stock four different formats of the HCFA Form 1500, used for filling out Medicare claims. The two-part carbonized snap-out form used most by doctors sells for $13.00 per 100-count package. Pre-payment is required, although there is no tax or no postage charge for 4th class mailings. Make check payable to Superintendent of Documents, or charge orders to MasterCard, Visa or Choice.

Government Printing Office Bookstore
Federal Building, Room 158
400 West Bay Street
Jacksonville, Florida
(904) 791-3801

GET MORE FOR YOUR ADVERTISING DOLLAR

Purchase A Display Ad in the

Journal of the Florida Medical Association, Inc.

Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203

(904) 356-1571

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name: _____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word.
Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

FAMILY PRACTICE opportunity: South Miami area. Board eligible or certified preferred. Excellent pay and working conditions. Affiliated with major medical center. Full or part-time. Respond with C.V. to Box C-1306, P.O. Box 2411, Jacksonville, FL 32203.

PRIMARY CARE CENTERS IN FLORIDA, NEW YORK, NEW JERSEY: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full time basis. Positions available in Central and South Florida coastal communities, central and northern New Jersey, and Long Island, New York area. Guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 930 South Harbor City Blvd., Suite 307, Melbourne, FL 32901.

DIAGNOSTIC RADIOLOGIST, Board Certified needed to join rapidly expanding hospital based solo-practice. Must have angiography/special procedures training/experience. Personable, willing to practice hands-on radiology. Large hospital located on the west coast of Florida, well equipped, MRI Pending. Box C-1329, P.O. Box 2411, Jacksonville, Fl. 32203.

OB-GYN WANTED: To join 14-man multi-specialty group. Must be board certified or board eligible. Competitive salary and excellent fringe benefits. Send CV reply to Medical Arts Clinic, Inc., 301 West Liberty, Farmington, MO 63640, Attention: Ronald G. Stevens, Adminitrator, or call (314) 756-6751.

FAMILY PHYSICIAN: Board eligible; for West Palm Beach practice. Florida license necessary. Opportunity for future partnership. 305-967-0234 Send C.V. to Benedicto San Pedro, M.D., 3444 S. Congress Ave., Lake Worth, FL 33461..

FAMILY PRACTICE PHYSICIAN — ORLANDO. Family physician for primary care centers serving migrant and indigent families. Good salary and benefits. Equal opportunity. Send C.V. to Gil Walter, P.O. Box 1249, Apopka, FL 32703, or call collect (305) 889-8427.

UROLOGIST needed with Florida license to join large fully equipped clinic in Pasco County the 7th fastest growing county in the United States. Send C.V. P.O. Box 36, New Port Richey, Florida 33552.

ORTHOPEDIC SURGEON needed with Florida license to join large fully equipped clinic serving a rapidly growing West Coast Florida community. Send C.V. P.O. Box 36, New Port Richey, Florida 33552.

A WEEK, A YEAR, A CAREER — Practice opportunities in Jacksonville, Miami, Orlando, Daytona Beach, Tampa. Options for permanent and/or locum tenens placements in all specialties. Trial associations with established practices in a variety of clinical settings. Call Suzanne J. Anderson at 800-833-3465 or write: Medstaff, Inc., P.O. Box 15538, Durham, NC 27704.

PRIMARY CARE GENERAL PRACTITIONER for state and county funded primary care clinic located in West Pasco County, Florida. Must have Florida license, and be willing to relocate. Call Diane Parker, Director, Primary Care Clinic at (813) 849-6940, or mail resume to the Pasco County Health Department, Primary Care Clinic, P.O. Box 160, New Port Richey, FL 34291-0160.

STAFF PSYCHIATRIST: Exciting opportunity for Florida-licensed, board eligible or certified psychiatrist, preferably with child/adolescent experience, to work full or part-time in a comprehensive JCAH-accredited mental health center and psychiatric hospital, one interested in quality psychiatric services. Primary duties include direct inpatient care with opportunities for a variety of outpatient services, an academic affiliation, and outside income. Salary competitive. Send letter of interest with resume to Dr. Anthony Broskowski, Northside Centers, Inc., 13301 N. 30th Street, Tampa, FL 33612, (813) 971-0192.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

GENERAL, THORACIC AND vascular surgeon wanted to join busy solo practitioner. Lovely Central Florida community with 500 bed hospital. Call (815) 299-7902 Monday-Friday 9:00-4:30 p.m.

N.W. FLORIDA, OB-GYN, BC/BE to join an expanding busy solo practice in the FL Panhandle on the Mexican Gulf Coast's most beautiful beaches. Metropolitan area of 280,000. Salary and benefit package leading to partnership. Please reply with CV to Linda H. Ferguson, 5120 Bayou Blvd., Suite 11, Pensacola, FL 32503.

OB-GYN NEEDED — productive and rewarding practice located in beautiful lake/river area of Florida needs third Ob-Gyn for potential partnership. Please respond to C-1335, P.O. Box 2411, Jacksonville, FL 32203.

FT. PIERCE, FLORIDA — Full time emergency department position available in a 240 bed hospital with an annual ED volume of 24,000. Candidate must be board prepared in emergency medicine. The hospital is centrally located between Disney World and Miami on Florida's Treasure Coast. Excellent compensation and malpractice insurance provided. Please send CV to Cheree Richards, EMSA, 8200 W. Sunrise Blvd., Plantation, FL 33322, or call (305 472-6922.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

ST. PETERSBURG, FL: Emergency Department physician. 42 hours per week. Nights and week-ends. Excellent compensation. Send C.V. to: Diane, P.O. Box 12077, St. Petersburg, FL 33733.

FAMILY PHYSICIAN or general internist to join busy Family Practice in Miami area. Associated with modern Medical Center. Board eligible or certified preferred. Pleasant working conditions. Call or send CV to: C-1333, P.O. Box 2411, Jacksonville, FL 32203.

E.R. FULL TIME OR part-time: East Coast — Community hospital, 12000 visits/year, excellent opportunity for board prepared/certified, E.M. or primary care specialty with E.R. experience. Excellent salary, small group and easy to arrange schedule, needed immediately. Call 672-4791 or 677-9183.

GROWING PRIMARY CARE Center on east coast central Florida needs a full time physician. Send CV to P.O. Box 524, Rockledge, FL 32955, or call Mrs. Moore, (305) 639-1601.

WANTED: A GENERAL SURGEON and urologist with in depth training in surgical urology and office urology to associate with D.O. on the west coast of Florida in active urological and general surgical practice. Please mail curriculum vitae with recent photograph to B. Warren Smith, D.O., 10333 Seminole Blvd., Largo, FL 33540.

PEDIATRICIAN — multi-specialty group in East Central Mississippi with three other pediatricians. Excellent fully equipped hospital, JCAH accredited. BC/BE. Initial salary with later productivity based income. Partnership in two years. No HMO/PPO affiliations. Send CV to Kenneth J. Reid Jr., M.D., Rush Medical Group, P.A., 1314 19th Avenue, Meridian, MS 39301.

OPHTHALMOLOGIST: wanted retired non-surgical ophthalmologist with Florida license to join large multi-specialty group practice. Send CV to C-1337, P.O. Box 2411, Jacksonville, FL 32203.

OB/GYN and Neurosurgeon: BE/BC OB/GYN needed for central Florida hospital near metropolitan area and BE/BC neurosurgeon needed for southern Florida hospital. Excellent opportunities to build practice. Cross coverage available. Affiliation with JCAH accredited, full-service hospitals. Generous relocation packages offered. Send CV to: Professional Relations, Nu-Med Hospitals, Inc., 16633 Venture Blvd., Encino, CA 91436.

TAMPA, FL — Excellent opportunity to become the primary physician of a well established growth oriented Family Practice in the fastest growing city in the South. Practice benefits include association with a specialty group, computerized management system, X-ray, Laboratory, Spirometry, modern offices in pleasant surroundings. We are seeking a Board Certified or Board Eligible Family Practitioner, highly motivated and dedicated to the delivery of quality health care. Excellent base salary plus strong incentives based on revenues. We will provide assistance with interview and relocation expense. If you would like to be an important part of our growing team, send your C.V. to John Q. Stauffer, M.D., 2919 Swann Avenue, Suite 205, Tampa, FL 33609, or call (813) 870-3971.

GENERAL & VASCULAR Surgeon: Daytona Beach — Join surgeon who is retiring in one (1) year — take over practice. Excellent opportunity for July '86. Must be Board Certified. Send CV to Box C-1334, P.O. Box 2411, Jacksonville, FL 32203.

CHILD AND ADOLESCENT PSYCHIATRIST. 80-100k salary. Send C.V. to: 8130 Baymeadows Circle, W., Suite 306, Jacksonville, FL 32216.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4204.

Situations Wanted

LOCUM-TENENS: RADIOLOGIST, Board Certified, un;iversity trained with academic background, age 47, experienced in most modalities, will consider office and/or hospital-based practice. Please write C-1311, P.O. Box 2411, Jacksonville, FL 32203.

FMG, ABIM, Gastroenterologist - University trained. Seeking practice opportunity in solo or group in Florida and South East United States, starting July 1986. Would consider other locations. C-1326, P.O. Box 2411, Jacksonville, FL 32203.

CARDIOLOGIST: Completed 3 years in internal medicine and 2 years in cardiololgy at the University of Miami. Will complete a year of cardiac catheterization and PTCA at the Miami Heart Institute in June 1986. Board certified in IM. Florida licensed. Wants Association, partnership, or a practice in West Palm Beach-Jupiter area. Ricardo A. Bedoya, M.D., 601 Alcazar Ave., Coral Gables, FL 33134.

WELL TRAINED BOARD certified female internist — seeks to buy established practice, internal medicine or family practice, in Florida starting June '86. C-1332, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

RETIREMENT MINDED OB-GYN in north Florida look ing for partner in practice grossing 400,000 t. Partnership immediately with transfer of practice in two years. C-1316, P.O. Box 2411, Jacksonville, FL 32203.

FLORIDA WEST COAST: Splendidly located, freestanding clinic for family practice or walk-in. Laboratory and x-ray. Rapidly expanding community. Nearby accredited hospital. Annual gross over 400,000.00. C-1321, P.O. Box 2411, Jacksonville, FL 32203.

FT. LAUDERDALE Radiology office building and equipment for sale. Siemens, Kodak and Technicare. d(305) 771-9500 or (305) 942-2946.

FOR LEASE: Fully equipped medical facility. Complete lab, x-ray, orthopedic and surgery departments. Suitable for solo or group practice. Will consider lease with option to buy. Contact J. Davis, P.O. Box 25337, Sarasota, FL 34277.

FOR SALE — Ft. Lauderdale. Busy Internal Medicine Practice, 5 years old, 2 office locations, physician relocating. Call Dr. West, 791-3278 after 9:00 p.m.

NAPLES, FL, Urologist retiring. Desires to sell desirable office building and equipment. Will give good terms to qualified urologist. Call 813-262-1521 or 813-262-3996.

UNOPPOSED GYNECOLOGICAL Practice for sale. Downtown Miami. Grossing $300,000.00 plus yearly. Efficient staff speaking English, Spanish and Creole. Will stay on. Terms negotiable.

Real Estate

SPRING HILL, FL - 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease - owner will finance. (904) 596-4162 weekdays.

HANDSOME SECOND INCOME: Franchise starting in Florida to physicians and dentist only; do not miss this opportunity call Bob Richardson (305) 977-9322.

SUB-LEASE: Medical/ Surgical Office, Ft. Lauderdale, FL. 1000 Sq. Ft. — Good Location — Partly equipped office — Consultation Room — 2 Exam Rooms, Waiting Room — Laboratory (305) 764-4442.

BEAUTIFUL WALK-IN Medical Center in beautiful Winter Haven, FL, loaded, excellent location in a cute shopping plaza. Terms cash. Call (813) 299-9000. Dr. Mangal.

DOCTOR MUST SELL new luxury prime condo, Park Plaza, 12th Floor. Three bedroom, two bath. Covered parking, pool, magnificent view St. Johns River and downtown Jacksonville. Dock available. Price reduced. Phone: (305) 278-1067.

TWENTY-SIX ACRES of beautiful mountain land, includes four streams, level farmland with bvarn, Robbinsville, N.C., near resorts. Ideal for development or dwelling. $40,000 (904) 733-1215 or (214) 234-6040.

MY FREE-STANDING optometric office of 24 years is for lease, 2700 squre feet, ½ mile to Memorial Hospital, personal off-street parking, 6817 Beach Blvd., R. H. Miller, O.D., 725-5076.

CAYMAN ISLANDS — modern 2 bedroom beach house on Cayman Brac. Superb snorkelling and scuba. Quiet out-island setting. Rental $350.00 per week. Dr. R. Lament, 2187 West 4th Avenue, Vancouver B.C. Canada (604) 733-5722.

FUTURE OFFICE SPACE: Available June 1986. Prime location north St. Petersburg. Will build to suit. Free standing professional building. George Stovall, (813)896-5371.

PHYSICIAN OWNER MUST SELL new fully furnished ocean front condo at Seawatch (Vilano Beach). On ocean, pool, tennis, covered parking. 2 bedroom, 2 bath. Price reduced. Phone (305) 278-1063.

NURSING HOMES AND ADULT congregate living facilities: limited partnerships. Earn over 16% Life Care Retirement Facilities, Inc. Contact Milton — (305) 891-0594 after 7:00 p.m.

Services

FINANCIAL SHELTERS IN Switzerland. Legal, secure, strictly confidential. For Information write: Assurex, S.A., P.O. Box 209-R, Volkmarstrasse 10, 8033, Zurich, Switzerland.

WHITEWING DOVE HUNTING: Excellent Bass Fishing and Duck Hunting. Lago Vista on Lake Guerrero, Mexico. Complete facilities and guides. No hassles. Fly into Harlingen, McAllen or Brownsville, Texas. We handle the rest. Any size group. Make reservations early; dove hunting starts mid August thru October. Paloma Guide Service (512) 883-7033 M-F. (512) 991-1761 or (512) 991-4197 nites.

ATTORNEY FOR PHYSICIANS for business, professional regulation, records, malpractice, and standard of care issues. Vitae: Doctor of Science, Health Services Administration (University of Pittsburgh); Juris Doctor, Law (Creighton University); 20 years health-care experience; Professor; publications. Licensed to practice law in Florida, Michigan, and Nebraska. Contact: Robert Woody, Attorney at Law, Suite 205, 1950 Courtney, Fort Myers, FL 33901; telephone (813) 939-4321.

WEEKEND INTENSIVE THERAPY for individual, marital, family problems. Sexual dysfunction. Certified Sex Therapist, AASECT. Licensed Marriage and Family Therapist. Contact: Jane Woody, Ph.D., Family Psychology Clinic, Suite 15, 1919 Courtney, Ft. Myers, FL 33901; telephone (813) 939-0607.

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, promptservice. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and preowned medical instrumentation: Holter-Stress-Ultrasound-EKG Lab etc. Contact New Life Systems, Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065; 305-972-4600.

ATTRACT NEW PATIENTS TO YOUR PRACTICE! *The Marketing Guide for Physicians* provides working knowledge and successful techniques to promote your practice. $6.50/copy. Order from the Pennsylvania Medical Society's Trust, 20 Erford Road, Lemonye, PA 17043 or call (717) 763-7151. Other publications also available.

Equipment

FOR SALE: Theta Col-R-Lite interoffice communication system. Will accommodate 8 rooms and has 5 lights with 3 master panels. Call Linda 936-8151.

FOR SALE: Elisa Reader; Dynatech Mini-reader II with cartridge and printer. This system has only been used a few times. New costs $6,000. For sale for $4,000.

Meetings

WEEKLY SEMINARS — Medical/Legal and Financial Management. Aspen, Disney World, Hollywood, FL, Nassau, Park City, Steamboat Springs, Sun Valley. Fee $185. For information: Current Concept Seminars 3301 Johnson St., Hollywood, FL 33021 (305) 966-1009. For reservations: (800) 428-6069. Meets the new risk management CME requirement.

Physicians' Confidential Assistance

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874 M D

THE FLORIDA MEDICAL FOUNDATION 1956

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

"Deafness is something you put beside you not in front of you."

LINDA BOVE / ACTRESS



PHOTO: HELEN NESTOR

Linda Bove performed with The National Theatre of the Deaf for nine years. She has also starred in the Tony Award winning show, *Children of a Lesser God*.

Believe in them. Break the barriers.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, WASHINGTON D.C. 20210

PRODUCED BY THE SCHOOL OF VISUAL ARTS PRESS, LTD.

ADVERTISERS

Air Force
Recruitment 444

Air Force Reserves
Recruitment 472

Army Reserves
Recruitment 438

Ayerst Laboratories
Inderal LA 482b
Inderide LA 482c

BellSouth Mobility
Service 435

Brown Pharmaceutical
Android 444
Lipo-Nicin 481

Bryant Bureau
Service 480

Buchanan & Co., Inc.
Investment 480

Chama Land & Cattle Company
Investment 480

Curtis 1000 Information Systems
Computers 445

Digit-Up
Service 472

Eli Lilly & Company
Ceclor 446

FMA Sponsored Insurance Plans
Service 456

Florida Physicians' Insurance Company
Service 434

GTE Telenet
Service 457

Info Systems
Computers 469

Janssen Pharmaceutica
Vermox 458

Knoll Pharmaceutical Company
Isoptin 434b
Vecodin 482f

Marion Laboratories, Inc.
Cardizem 434e

Medical Expo '86
Meeting 472

Medical World News
Publication 458

Roche Products, Inc.
Dalmane 495

Smith Kline & French Laboratories
Dyazide 434a, 482e

University of Miami
Meeting 481

Upjohn Company
Motrin 482a

Willingway Hospital
Service 469

Wyeth Laboratories
WyTensin 482b

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D., Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

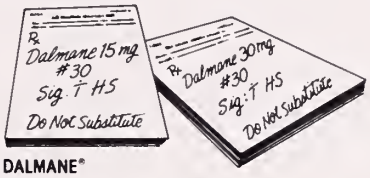
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
brand of
flurazepam HCl/Roche Ⓥ
sleep that satisfies

15-mg/30-mg
capsules



References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Koles A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Koles A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Koles A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Koles A, Koles JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennont FS, *et al:* Symposium on the Treotment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblott DJ, Allen MD, Shoder RI: *Clin Pharmacol Ther 21*:355-361, Mor 1977.



DALMANE®
brand of
flurozepam HCl/Roche Ⓥ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnio chorocterized by difficulty in folling osleep, frequent nocturnol owokenings ond/or eorly morning owokening, in patients with recurring insomnio or poor sleeping hobits, in ocute or chronic medicol situotions requiring restful sleep. Objective sleep laboratary doto hove shown effectiveness for ot leost 28 consecutive nights of odministrotion. Since insomnio is often transient and intermittent, prolonged administration is generolly not necessary or recommended. Repeated therapy should only be undertoken with oppropriote potient evoluotion.

Controindicotions: Known hypersensitivity to flurazepam HCl; pregnoncy. Benzodiozepines moy couse fetal damage when odministered during pregnoncy. Several studies suggest an increased risk of congenital molformations ossocioted with benzodiazepine use during the first trimester. Worn potients of the potentiol risks to the fetus should the possibility of becoming pregnont exist while receiving flurozepom. Instruct potients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnoncy prior to instituting therapy

Warnings: Coution potients obout possible combined effects with olcohol ond other CNS depressants. An additive effect moy occur if alcohol is consumed the day following use for nighttime sedation. This potentiol moy exist for severol doys following discontinuotion. Coution ogoinst hozardous occupotions requiring complete mentol alertness (*e g*, operoting mochinery, driving). Potentiol impoirment of performonce of such octivities moy occur the doy following ingestion. Not recommended for use in persons under 15 yeors of oge Withdrowol symptoms rorely reported, abrupt discontinuation should be ovoided with graduol topering of dosage for those patients on medication for o prolonged periad af time Use coutian in odministering to addiction-prone individuals or those who might increose dosage

Precautions: In elderly ond debilitoted potients, it is recommended thot the dosoge be limited to 15 mg to reduce risk of oversedotion, dizziness, confusion ond/or otoxia. Consider potential oddilive effects with other hypnotics or CNS depressants. Employ usuol precoutions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheodedness, stoggering, otoxio ond folling hove occurred, porticulorly in elderly or debilitoted potients. Severe sedotion, lethorgy, disorientation ond como, probably indicative of drug intolerance or overdosage, hove been reported. Also reported. headache, heortburn, upset stomoch, nousea, vamiting, diarrhea, constipotion, GI pain, nervousness, talkativeness, opprehension, irritobility, weokness, polpitotions, chest poins, body ond joint poins ond GU complaints. There hove olso been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter toste, excessive salivotion, anorexio, eupharia, depression, slurred speech, confusian, restlessness, hollucinations, ond elevoted SGOT, SGPT, totol ond direct bilirubins, ond olkaline phosphotase; and porodoxicol reactions, *e g*, excitement, stimulation and hyperactivity

Dosoge: Individuolize for moximum beneficiol effect. *Adults* 30 mg usuol dosoge; 15 mg moy suffice in some potients *Elderly or debilitated patients*: 15 mg recommended initiolly until response is determined.

Supplied: Capsules contoining 15 mg or 30 mg flurozepom HCl

ROCHE®
Roche Products Inc.
Monoti, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see preceding page for summary of product information.

DALMANE®
brand of
flurazepam HCl/Roche ⓒ
sleep that satisfies



7 C01183 COC 2
COLL.OF PHYS.OF PHIL. ELPHIA
LIBRARY
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103
3

ROCHE®

Copyright © 1986 by Roche Products Inc. All rights reserved.

STACKS

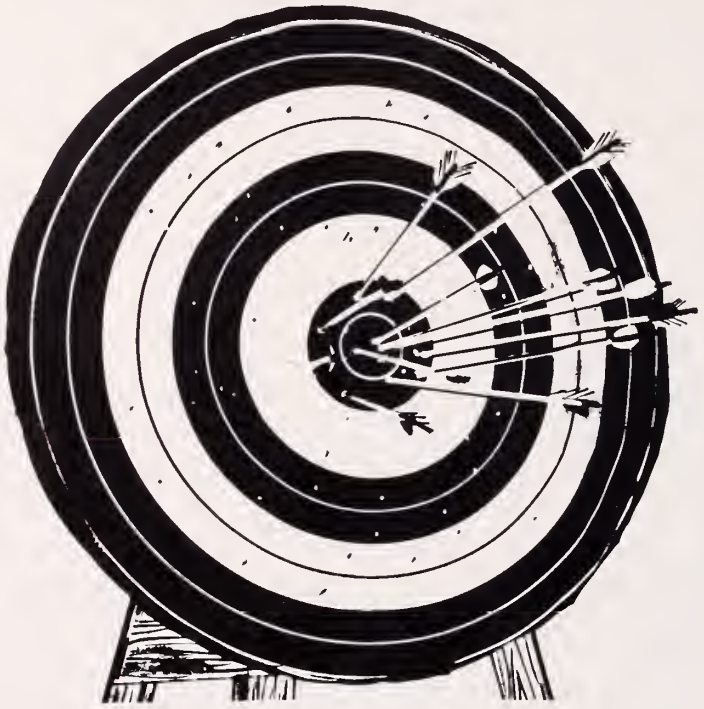
THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. JULY 1986, Vol. 73, No. 7

COLLEGE OF
OF PHYSICIANS
AUG 5 - 1986
M. D. S.

Prison health care



BULLSEYE!



The center of the target is where you aim and score. Florida Physicians Insurance Company has the professional management skills to keep you on target at all times! Florida owned and operated with NO assessment features. Sponsored by the Florida Medical Association.

You deserve to hit the target !

For more information call Ron Gladman:

FPIC FLORIDA PHYSICIANS INSURANCE COMPANY

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

FMF IMPAIRED PHYSICIANS NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

July 1986 "Doctors Helping Doctors" Vol. 3 — No. 2

Governors Approve Cocaine Handbook

The FMA Board of Governors has given an enthusiastic stamp of approval to publication of a physician handbook on cocaine.

The project was conceived by the FMA Committee on Substance Abuse, which is chaired by Joseph H. Deatsch, M.D., of Jacksonville. Miami Beach addictionologist John C. Eustace, M.D., was named to head up the project.

According to Dr. Deatsch, the typical cocaine addict often consults a physician for depression, weight loss and other symptoms directly related to his addiction. The new handbook will help physicians assess the possibility of cocaine addiction and provide advice on treatment and referral.

In authorizing funds sufficient to provide every doctor of medicine and doctor of osteopathy in Florida with a copy, the FMA Board asked that the publication be completed and distributed as soon as possible.

In another action at its meeting on June 28, the FMA Board approved the outline for a 4½-day course on prescription drugs, which was developed by Dr. Deatsch's Committee. The course is designed primarily for physicians who have been cited for improper prescribing, but any physician who wishes to enroll may do so.

(Continued on Next Page)

IP Workshop Draws 73 Participants

Seventy-three physicians and others attended the Seventh FMA-FMF Workshop on Intervention with Impaired Physicians in Hollywood, March 22-23.

Keynote speaker was LeClair Bissell, M.D., of Sanibel Island, Past President of the American Medical Society on Alcoholism. Barton A. Harris, M.D., of Lake Success, N.Y., Medical Director of New York's Impaired Physician Program, was a special guest.

The program differed from previous workshops in that it focused on support groups and other after care issues.

New Impaired Physician Program Is Enacted by State Legislature

The Florida Legislature has taken a major step toward protecting impaired physicians and other health care providers from disciplinary action while they are in treatment for chemical addiction.

In a related action, the lawmakers, in a special session on June 19, set the stage for a possible contractual relationship between the Department of Professional Regulation and the FMA-FMF Impaired Physicians Program, a goal long sought by the Committee on Impaired Physicians.

The Legislature established a 16-member Impaired Practitioners Committee within DPR which will consist of representatives of virtually all of the licensed health care professions, including medicine. It replaces a smaller Impaired Professionals Advisory Committee, which has been operating for the last few years.

In the state budget adopted by the Legislature, DPR was authorized to spend up to $100,000 "to contract with the Florida Medical Foundation, Inc. for the purpose of providing consulting services for the Impaired Professional Program."

The contract authorization is important because DPR officials cited lack of statutory authority in backing off from a proposed agreement with the Foundation and IPP Medical Director Roger A. Goetz, M.D., early this year, according to Guy T. Selander, M.D., of Jacksonville, Chairman of the FMF Committee on Impaired Physicians.

"We believe that an official liaison between our program and the DPR is in the best interest of all concerned, particularly our impaired health care providers," Dr. Selander commented. "We have been preaching this for years, and now we may be on the threshold of achieving it."

The new law, which goes into effect on October 1, empowers the Impaired Practitioners Committee to: develop policies and guidelines for approving treatment programs; serve as liaison between approved treatment providers and DPR; advise DPR on the continuation and expansion of treatment programs; and distribute information about the program. DPR also is authorized to hire one or more impaired practitioner consultants, which could be doctors of medicine or other licensed health care providers.

(Continued on Next Page)

Chemical Dependency Program Announced

Donald I. MacDonald, M.D., a former Clearwater pediatrician who now occupies one of the highest medical posts in the Federal Government, will be the principal speaker at the Sixth Annual Section on Chemical Dependency during the 1986 FMA Annual Meeting.

Although plans for the Section have not been completed, Program Co-Chairman Arvey I. Rogers, M.D., said Dr. Macdonald's tentative topic is "Substance Abuse: A View from the Top."

The Section will be presented from 1:30 p.m. to 5:00 p.m. on Wednesday, September 17, at the Diplomat Hotel in Hollywood under the sponsorship of the FMF Committee on Impaired Physicians. The program is co-sponsored by the Florida Chapter of the American Medical Society on Alcoholism.

Dr. Macdonald moved to Washington in 1984 when President Reagan appointed him as Administrator of the federal Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). For several months he served as Acting Assistant Secretary for Health of the Department of Health and Human Services until another Floridian, Robert E. Windom, M.D., of Sarasota, was confirmed for the post.

Dr. Macdonald returns to Florida from time to time for speaking engagements. During his visit to the FMA he will receive a plaque, authorized by the Board of Governors, commending him for his many contributions in the field of substance abuse.

New Impaired (Con't)

The law applies to health care practitioners whose misuse or abuse of alcohol and other drugs or whose mental condition could affect their ability to practice their profession.

Such a practitioner would be diverted from the DPR's disciplinary process if there are no other complaints against him; if he has acknowledged his impairment problem; if he has voluntarily enrolled in an approved treatment program; and if he has withdrawn from practice or limited the scope of his practice as determined by the probable cause panel of his licensing board.

Other key provisions of the new law include:

— Withdrawal of hospital staff privileges due to impairment does not constitute a complaint against the practitioner.

— Treatment providers must upon request disclose to the consultant all information they have regarding a practitioner in treatment. This information is exempt from disclosure and is to be held confidential.

— Consultants, treatment providers and licensed practitioners who provide information about an impaired practitioner are exempt from civil liability.

The Impaired Practitioners Committee is to consist of one each acupuncturist, doctor of medicine, doctor of osteopathy, chiropractor, podiatrist, optometrist, nurse, pharmacist, dentist, midwife, veterinarian, optician and physical therapist. One addictionologist, one lay member with a background in impairment and one appointee of the Department of Professional Regulation round out the Committee.

The consultants must be licensed practitioners of any of these professions.

IP Program Having Successful Year

FMA's Impaired Physician Program is enjoying one of the most successful years since it began in 1980, according to Guy T. Selander, M.D., Chairman of the Committee on Impaired Physicians.

"Since the retention of Roger A. Goetz, M.D., as fulltime medical director in February of 1985, intake into the program has increased dramatically and relationships with other health professions have been established or strengthened and improved," Dr. Selander stated in a report prepared for the 1986 FMA House of Delegates.

During the 17-month period from January 1, 1985 to June 1 of this year, 180 physicians and other health care providers were seen in the program. This is four more than the total enrolled for all of 1981 through 1984. As of June 1, the program had recorded 371 cases.

Mixing Alcohol with Other Drugs Often Causes Bad Interactions

(Second of a Series)

Alcohol and other drugs often do not mix well; they can produce undesirable interactions. In the January issue of *Impaired Physician Newsletter,* we began publishing a drug-alcohol interaction chart that originally appeared in *Modern Medicine.*

The chart continues:

Drug: Barbiturates

Effect: Increased alcohol metabolism, inhibited barbiturate metabolism, and increased CNS depression may occur.

Comments: Use together only with caution.

References: Juhl RP, et al. J Clin Pharmacol 1984;24:113.

Drug: Benzodiazepines

Effect: Additive CNS depression and potential serious toxicity occur.

Comments: Marked decrease in driving and psychomotor skills occurs; avoid concurrent use.

References: Sellers EM, et al. Clin Pharacol Ther 1980;28:638.

Drug: Cephalosporins

Effect: "Antabuse-type" reactions have occurred.

Comments: Avoid alcohol within 2 or 3 days of stopping the antibiotic.

References: Elebaas RM, et al. Clin Pharmacol Ther. 1982;32:347.

Drug: Chloral hydrate (Noctec, et al)

Effect: Mutual inhibition of metabolism occurs.

Comments: Markedly increased CNS effects result; exacerbation of cardiovascular problems may occur.

References: Sellers EM, et al. Clin Pharmacol Ther 1972;13:50.

Drug: Cimetidine (Tagamet)

Effect: Alcohol metabolism inhibition and increased GI absorption may occur.

Comments: Caution patients of the potential for exaggerated effects of alcohol.

References: Glaser D, deTarnowsky GO Jr Ann Intern Med 1983;98:413.

Ohio Physicians Win Confidentiality Fight

The Ohio State Medical Association and other professional groups have won an important victory over the state licensing board for confidentiality in impaired professional treatment programs.

As a result, treatment programs will not be required to report to the State Medical Board the names of physicians entering treatment. The Ohio Legislature had demanded that the Medical Board submit a plan for handling impaired physicians by last March 31.

Accordingly, the Board approved a bill that would require treatment programs to report to it the names of physicians entering therapy. The Board would keep the identities of the doctors confidential as long as they satisfactorily completed the program and experienced no more problems.

But Board Vice President William W. Johnston of Columbus said the Board backed down on this language when the medical association, the Ohio Osteopathic Association and the Ohio Podiatric Medical Association threatened to lobby to defeat the measure.

The proposed legislation still will protect the public adequately because treatment programs will be required to make the doctors quit practice while in therapy, Johnston added.

Ms. Carol Rolfes, a consumer member of the Board and the only Board member who formally objected to the revision, charged that the Board got "a bad deal."

Confidential Assistance Call (904) 354-3397

Governors Approve (Con't)

According to Dr. Deatsch, it is hoped that the course can be offered for the first time at the University of South Florida College of Medicine later this year. The AMA Substance Abuse Unit and Pierre J. Bouis, M.D., Associate Dean for Continuing Medical Education at USF and Chairman of the FMA Council on Scientific Activities, have been assisting the Committee on Substance Abuse with the project.

Motrin® 800 mg TABLETS
ibuprofen



Extra strength
Convenience
Economy

Upjohn
A Century of Caring
1886·1986

©1986 The Upjohn Company

J-6138 January 1986

AMERICAN MEDICAL INTERNATIONAL'S PHYSICIAN PLACEMENT SERVICE



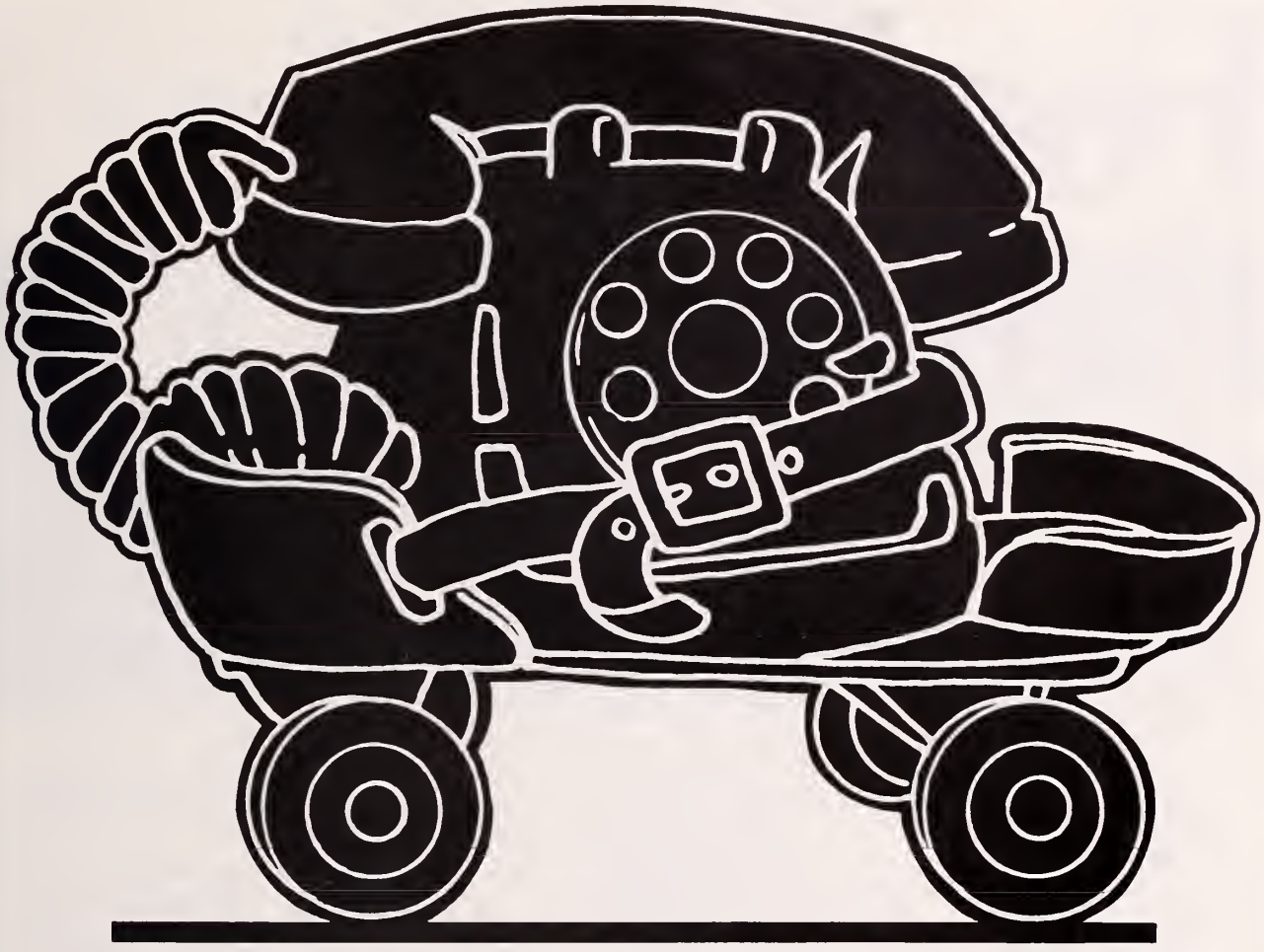
American Medical International has instituted a corporate service to assist Physicians interested in servicing AMI hospitals in fee-for-service private, solo, group, or other multi-specialty practices. Current opportunities are available for physicians who are Board Certified or Eligible. There is no charge to physicians for this service.
Specific areas of interest are:

- **Family Practice**
- **Neurology**
- **Ophthalmology**
- **Orthopedics**
- **Gastroenterology**
- **ENT**
- **Oncology**
- **General Surgery**
- **VAS Surgery**
- **Neurosurgery**
- **Orthopedic Surgery**
- **Occupational Medicine**
- **Cardiology**
- **Rheumatology**
- **OB/GYN**
- **Internal Medicine**

Physicians interested in pursuing these opportunities should contact this service by calling or submitting a curriculum vitae to:

Norman Penick
Vice President
Human Resources
AMI
9465 Wilshire Blvd., Ste. 915
Beverly Hills, CA 90212
Call Collect: (213) 858-6927
Call Toll Free: (800) 533-7013
(800) 325-4881

AMI



Car Phones Explained.

A car phone is just a phone on wheels. Like the ones in your kitchen, your bedroom, your office. And for an incredibly affordable price, you'll find there's nothing simpler or more convenient than having a phone in *your* car. Maybe that's why BellSouth Mobility has put more phones on wheels than anyone in the Southeast.

For full details, call BellSouth Mobility today at **1-800-351-3355.** Because all the way from Jupiter to Florida City, we really are the phone company for your car.



The Phone Company For Your Car.℠

BellSouth Mobility
A ***BELL****SOUTH* **Company**

©1986 BellSouth Mobility

For Your Benefit...

From The Florida Medical Association Sponsored Insurance Plans.

Diagnosis: FMA Members and Employees, Need Dependable, Comprehensive Coverage In Medical Care, Life, Disability and Dental At Economical Group Rates

Treatment: Enroll NOW in Your Florida Medical Association Sponsored Insurance Plans

Prognosis: Excellent. FMA-SIP Offers Flexibility, Convenience, Efficiency In An Insurance Package Designed Exclusively For You.

• Major Medical • Dental • Short-Term Disability • Life And AD&D

☐ Developed from your specifications by your Association and offered exclusively to FMA members and their employees. Dependents coverage available for Medical and Dental benefits.

☐ Marketing by Florida's leading insurance consultant, Brown and Brown, Inc., for further information contact us at the toll free number below.

☐ Underwritten by one of America's largest and strongest insurance companies, Mutual of Omaha.

☐ Administered by FLAMEDCO, Inc., highly regarded for rapid, efficient claims and enrollment administration and a wholly owned subsidiary of your own Florida Medical Association.

FMA/SIP Offers You Great Flexibility. You Choose The Coverage You Need:

Major Medical, Million-dollar protection with your choice of $200 or $500 annual deductibles and the new Medical Deluxe Plan.

Dental, Benefits of up to $1,000 per person each year. Optional if you elect Major Medical.

Life, Group term life insurance coverage for you and your employees. You select coverage level from $10,000 to $100,000.

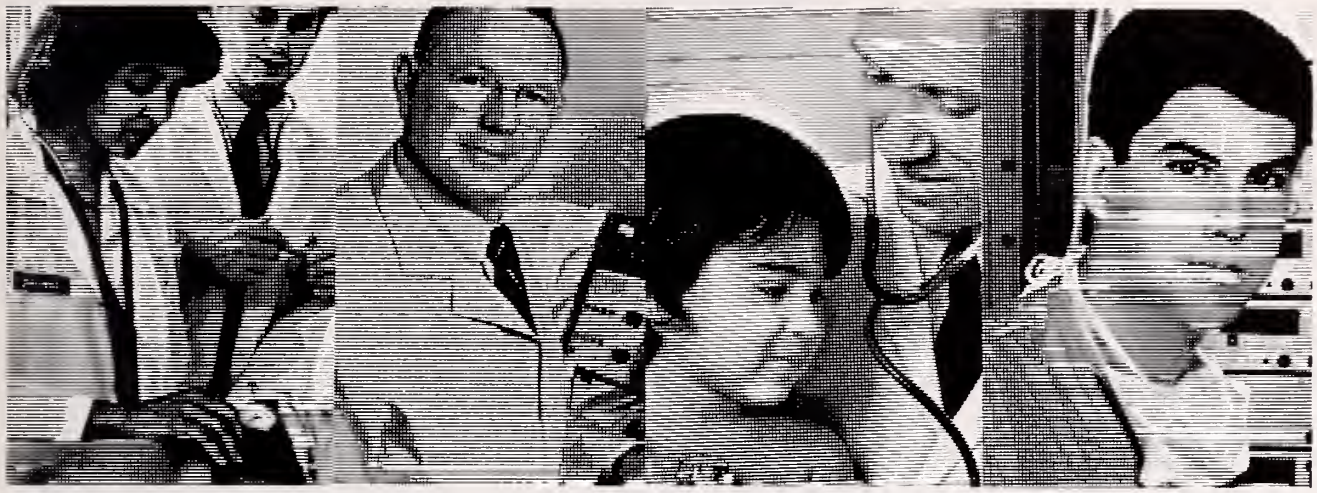
Disability, If you elect life insurance, you also may choose from among four short-term disability options, either 13-week or 26-week coverage with or without maternity.

Call Toll-Free
1-800-624-3953 *For Details*
P.O. Box 4938
Jacksonville, Florida 32201



Florida Medical Association, Inc.
Sponsored Insurance Programs

FAMILY PRACTICE. A REWARDING EXPERIENCE IN ARMY MEDICINE.



THE ARMY RESERVE IN THE SOUTHEAST NEEDS PHYSICIANS WHO SPECIALIZE IN FAMILY PRACTICE, TO JOIN AN EXCEPTIONAL TEAM.

WE UNDERSTAND THE DEMANDS ON A BUSY PRACTITIONER. SO WE'RE FLEXIBLE ABOUT TIME, PARTICULARLY WHEN IT'S TIME YOU WANT TO SHARE WITH YOUR COUNTRY.

IN THE ARMY RESERVE, YOU'LL FIND OPPORTUNITIES THAT ARE CHALLENGING AND VARIED. OPPORTUNITIES TO PARTICIPATE IN EXCITING TRAINING PROGRAMS AND WORK WITH OUTSTANDING PHYSICIANS FROM EVERY AREA OF THE COUNTRY AND TO EXTEND ASPECTS OF YOUR SPECIALITY. WE THINK A FIRST PHONE CALL COULD PROVE TO BE REWARDING.

THE ACTIVE ARMY HAS MORE SOLDIERS WITH FAMILIES THAN EVER BEFORE. SO WHEN YOU JOIN THE ARMY MEDICAL TEAM AS A FAMILY PRACTITIONER, EXPECT TO SPEND MOST OF YOUR TIME SERVING NOT ONLY SOLDIERS, BUT THEIR SPOUSES AND CHILDREN, TOO. WHAT'S MORE, YOU WON'T HAVE TO WORRY ABOUT THE PAPERWORK, MALPRACTICE INSURANCE PREMIUMS, OR THE COSTS INCURRED IN RUNNING A PRIVATE PRACTICE.

WORKING WITH A TEAM OF HIGHLY TRAINED PROFESSIONALS, YOU CAN RECEIVE ASSIGNMENTS ALMOST ANYWHERE IN THE U.S. AS WELL AS OVERSEAS. PLUS UP TO 30 DAYS OF PAID VACATION AND REASONABLE WORK HOURS.

ALL IN ALL, YOUR ARMY FAMILY PRACTICE WILL BE A REWARDING EXPERIENCE.

TALK TO YOUR LOCAL U.S. ARMY OR ARMY RESERVE MEDICAL DEPARTMENT COUNSELOR FOR MORE INFORMATION ON FAMILY PRACTICE IN THE ARMY.

ARMY/ARMY RESERVE MEDICINE
3101 MAGUIRE BLVD
ESSEX BLD, SUITE 166
ORLANDO, FL 32803
CALL COLLECT: (305) 896-0780

ARMY. ARMY RESERVE. BE ALL YOU CAN BE.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JULY 1986, Vol. 73, No. 7

CONTENTS

SCIENTIFIC ARTICLES

David Black, D.V.M., M.S., M.D., and Tadeusz J. Wiktor, D.V.M. 517 Survey of raccoon hunters for rabies antibody titers: pilot study

Rif S. El-Mallakh, M.D., Donald L. Baumgartner, M.S., and Naguib Fares, M.D. 521 "Sting" of Puss Caterpillar, *Megalopyge opercularis* (Lepidoptera: Megalopygidae): first report of cases from Florida and review of literature

Donald F. Temple, M.D., F.A.C.S. 526 Adenocarcinoma of small intestine (25 year review — Roswell Park)

SPECIAL ARTICLES

Jacqueline M. Moore, R.N., M.S.N. 531 Prison health care: problems and alternatives in delivery of health care to the incarcerated — Part I

Richard J. Feinstein, M.D. 536 Confessions of a would-be health care entrepreneur

COVER

This month's cover of *The Journal* is a photograph depicting the special article in this issue entitled "Prison health care: problems and alternatives in delivery of health care to the incarcerated — Part I." The photograph was submitted by Jacqueline M. Moore, R.N., M.S.N., of Prison Health Services, Inc., Wilmington, Delaware.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.* [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc., are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Florida Medical Association, Inc.

DEPARTMENTS

505 President's Page
The challenge continues
Luis M. Perez, M.D.

507 Editorials
Getting tough on incompetent physicians
R.G. Lacsamana, M.D.
Put them on the flanks — and watch 'em, watch 'em!
H. Frank Farmer, M.D., Ph.D.
Warning: more lawsuits ahead, but solutions in sight
Lee A. Fischer, M.D.

513 Letters & Viewpoints

541 Medical Economics
Health Maintenance Organizations: 1986 Update
Jacques R. Caldwell, M.D.

547 Notes & News

548 Encores!

553 Book Reviews
Rx for the wounds of healing: the managerial imperative
Jacques R. Caldwell, M.D.

559 FMA Auxiliary
Acquaint yourself with Auxiliary programs
Mrs. Carl (Tommy Jean) Redderson

562 Deaths

566 Meetings

568 Classified Advertising

574 Index to Advertisers

574 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Karl Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

**FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC.
P.O. BOX 2411, JACKSONVILLE, FL 32203
TELEPHONE 904/356-1571**

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

The challenge continues



The recently passed liability bill is in the courts. Its constitutionality has been challenged on the basis that it addresses more than one subject.

The opponents suggest that the bill improperly embraces insurance regulations and tort reform.

The position of FMA is that it addresses only one problem, liability, with two-pronged solutions, one in insurance and one on tort reform that complement each other.

FMA never accepted the insurance part of the bill as passed and during the legislative session tried to influence the leadership of the House and the Senate to modify it to a more logical and simpler procedure, but insistance of attorneys in both Houses was so strong that it could not be achieved.

This places us in a quandary. If it is declared unconstitutional, next year we will have to re-do our work to achieve the ends in a separate bill.

In the meantime we have to start preparing for a political campaign in November to unseat those legislators who opposed us, and engineer the situation knowing that it very likely will be challenged, as it has been, and help those who did stay at our side to allow us to pass the tort reforms that we were able to obtain.

To achieve this we have to be able to organize the districts that are to be targeted at the earliest possible time and concentrate our efforts on the election of the right candidates. We have to be willing to be involved in the campaign with contributions in money and in time or both and be active in our offices, clubs, civic organizations and churches.

It is time that we use our clout and prestige in the community in a direct and effective manner, and this is the opportunity to do so. As physicians we have a tremendous force and, united with the local members of our coalition, we can and will mobilize a large number of voters to achieve our purpose.

As I wrote to you last month, we did take a step in the right direction. Now we have to continue in this long journey to solve completely this liability problem in the next year or two.

Let us employ every opportunity.





Her brother had Duchenne Muscular Dystrophy. Which means that though she herself is unaffected by the disease, she could be *carrying* it in her genes.

And if she is, there's a one-in-four chance her child will inherit Duchenne.

One of the most common and devastating forms of muscular dystrophy, Duchenne is usually passed from mother to child by a defective gene. The task of MDA researchers is to find that gene. And right now they're so close that MDA is pouring all possible resources into the quest.

Once the gene for Duchenne is identified, carriers can be identified, too —with 100% certainty. And the first major step toward finding a cure will have been taken.

MDA

Muscular Dystrophy Association, Jerry Lewis, National Chairman

Getting tough on incompetent physicians

The issue of incompetent physicians and what to do about them simply refuses to die. Ironically, physicians are now forcing the issue. The AMA in its recent annual meeting in Chicago announced major proposals to deal with the problem in an obvious move to blunt public criticism and to reinforce its commitment to weed out the incompetents from the profession. John Coury, M.D., the newly installed president of the AMA, made sure that the AMA's move was no mere rhetoric when he promised that one of his two major efforts for the year will be to clean the house of medicine.

The mounting and sometimes strident criticism against the medical profession for doing too little against incompetent physicians no doubt goaded the AMA into its new posture. For some time now, particularly within the last few years when physicians from across the nation barnstormed state legislatures for tort reforms, lawyers have succeeded in sidetracking the real issues by pointing at physician incompetence as the real culprit behind the escalating malpractice problem. Periodically, in newspapers across the country, reports are rampant of physicians with licenses suspended in one or more states but surfacing in another state, plying their business as usual until problems crop up, at which point they move on safely elsewhere, until perhaps the law catches up with them again. And just last year, in a blistering report against his colleagues, Sidney Wolfe, M.D., and his public health policy group out of Washington, D.C., castigated the medical profession for the tiny numbers of physicians disciplined by state medical boards across the nation.

While there is some kernel of truth in these criticisms, they do not portray the real situation and the difficulties that physicians face in dealing with their incompetent colleagues. There is no truth, for example, in the common public perception that physicians are mollycoddling incompetent practitioners and that they are in a conspiracy of silence to protect these wayward colleagues. Neither is there any truth to lawyers' allegations that purging the medical profession of what they perceive to be "medical incompetents" will solve the liability crisis. The pervasive nature of the problem across all lines of American society belies the lawyers' claim. It is true that few physicians relative to their numbers have been disciplined by state boards, but this is not the fault of physicians. It is the system that is at fault. Working with little authority and under all kinds of constraints, physicians have seen disciplinary proceedings degenerate into exercises of futility and into a big waste of time, manpower, and money, with threats of suits and countersuits at the same time.

By-laws for hospital medical staffs and medical societies with provisions for credentialing applicants, reviewing their performance, and disciplining them where there are grounds to do so theoretically should help us weed out the incompetents. But those of us who have served in hospital and medical society committees have found out there are a number of limitations and imperfections even with all these processes in place. For example, there is no central pool of information covering the background of every licensed physician in the United States, which is why certain physicians who cannot practice in some areas can do so in others simply by covering up their tainted background. In addition, a big number of physicians do not belong either to the county medical society or the AMA, making it impossible for local medical societies to investigate complaints and allegations against these non-members. But even in situations where local medical societies have jurisdiction, they still do not have the authority to suspend the licenses

of those expelled from these societies, which means that a physician who is found to be grossly incompetent can continue to ply his wares and harm patients until the Department of Professional Regulations disposes of his case. And as everybody knows, that can be an interminably long time particularly where due process becomes abused as an instrument to prostitute the system.

There is a real need to improve the system if we have to succeed in cleaning up our own house. Certain proposals from the AMA need serious consideration, including mandating the JCAH to require every hospital to consult an AMA central file on every physician applicant, and offering money or legal help to medical societies while doing their jobs of assuring only competent and ethical physicians for the public. Making membership in the local medical society and the AMA as a mandatory condition for licensure will remove a long-standing obstacle at looking at those physicians who are now non-members of organized medicine, but is unlikely to survive legal challenges. Tightening the credentialing, peer review, and disciplinary processes should be looked into; alongside this, local physicians serving on disciplinary committees should have more statutory authority to discipline erring colleagues and be provided with immunity from lawsuits while in the performance of their duties. Giving the Board of Medical Examiners more autonomy and perhaps making it independent of the DPR, as has been done successfully in California, Arizona, and Washington, may need to be considered in future legislation. While this is being studied, the DPR definitely needs to have more funding and increased staffing to do an efficient job. The increasing number of physicians coming to Florida to serve its burgeoning population will create even larger demands for the DPR in the next few years. Finally, there should be sharing of information among state medical boards concerning physicians with bad credentials to patch up what has become a big loophole in obtaining licenses.

A restless public getting increasingly skeptical about our ability to police our ranks needs to be assured that we can clean up our house of undesirable members if we are given the means and the authority to do so. The job becomes even more urgent at a time when it is so easy to acquire medical credentials, even faked credentials. In heeding AMA's call for tougher discipline, it is time for us to bury forever the notion that medicine is a closed society and to assure our patients that we will not tolerate misfits and scoundrels in our ranks.

R. G. Lacsamana, M.D.
Editor

Put them on the flanks — and watch 'em, watch 'em!

Recently, I wrote an editorial for our local county medical society. In that editorial I made the point, or attempted to, that the trial attorneys may have a valid perspective when they say that insurance companies will not reduce premiums in response to changing liability laws, such as setting limits on noneconomic damages or changing the doctrine of joint and several liability. I also pointed out that I am an ally with insurance companies — at least with our present struggles to reform the tort system. I am in favor of changing the tort system as I think this is necessary to change the ever increasing cost of liability insurance or its unavailability at any cost. I said this to make it quite clear to my physician colleagues that I had not gone over to the position of the trial attorneys. With that in mind, I would like to reiterate some points in my discussion and enlarge on certain thoughts which have been influenced by events since I wrote the editorial.

Over the past year I have been led to believe that if a limit was set on noneconomic damages and if the doctrine of joint and several liability was changed, then the insurance companies would better be able to evaluate their projected losses and, more importantly, would be able to stop the astronomically escalating liability premiums. How did I come to this conclusion? Recently I have been asking myself that question. The answer, I think, (unless I have been hallucinating over the past year), is that the insurance industry has been saying this. I cannot produce any editorials by insurance executives that make these statements in cold, hard prose, but I drew my conclusions based on statements and innuendos from the insurance industry. What makes it so important for any doctor to recall this is that since near the end of the recent session of the Florida Legislature, the insurance companies have denied that they have ever said or insinuated that lower limits on suffering and pain and repeal of joint and several liability would mean the stabilization of medical liability insurance premiums.

Now, this is simply too much. Certainly they insinuated it, said it and placed the blame for the rising liability costs squarely at the foot of the tort system. The message was simple. Reform the tort system and see a stabilization and even a reduction of insurance costs. To back up its claims, the insurance industry provided several startling facts. They were quick to point out that Florida holds the distinction of having the most jury awards of over $1,000,000. In addition, in 1984, there were almost 80,000 negligent cases heard in Florida circuit and county courts, indicating that the court system was turning into a giant lottery with astronomical awards, which

the insurance industry could not predict nor live with. Lloyds of London told the administrator of Saint Vincent's Medical Center in Jacksonville that it was unwilling to back further liability losses in Florida until the Florida Legislature undertook significant tort reform. Well, this is exactly what the Legislature has done.

We physicians planned our attack, allied ourselves with other interests, including the insurance industry which had assured the doctors in Florida that significant tort reform would lower premiums. We believed this and marched off almost in a holy war with the insurance companies hand in hand to do battle with the trial attorneys and convince the Legislature of the righteousness of our cause. The insurance industry was a trusted ally. You might say we trusted them guarding the flank of our forward charge. Slash and stab, move forward in concert, no break in the ranks! Morale was high and off to Tallahassee we marched. This was great! We had assurances from the insurance industry that they were with us. Sure, they were with us to get a cap on noneconomic damages and repeal joint and several liability. However, they were apparently not with us to limit increases on liability policies.

Perhaps we should have paid more attention to what was going on in the insurance industry other than what the physicians in Florida were being told by the industry's spokesmen. Recently, I read two articles by attorneys. One was by Stephen Masterson, Executive Director of the Academy of Florida Trial Lawyers, and the other by Mr. William Chanfrau, a trial attorney from Daytona Beach, Florida. Both articles contained some very interesting information and I will recapitulate some of that. In March of 1986, Franklin Nutter, President of the Alliance of American Insurers, said "it is clearly impossible to say that if you adopt a certain tort reform, you will get X reductions in premiums." The Maryland Legislature passed a cap of $350,000 in the spring of 1986. After the session, the head of the Medical-Mutual Liability Insurance Society of Maryland said the bill would not affect many claims and then requested a 50% rate increase. What? That is not the way it is supposed to work. I must admit I did not know this. I was too busy listening to the insurance companies telling us that the liability crisis would be solved if only if we had tort reform. It probably would — for them. The Iowa Legislature passed some measures of tort reform which were supported by the insurance industry but the majority leader of the Iowa senate said in retrospect that the changes had no effect on premiums or availablity of insurance.

However, I did not know these things as the Florida Legislature, under great public pressure, made it clear that there were going to be some changes in the tort system. Everything was going our way. Toward the end of the session a legislature had a great idea. If reforms of the tort system were going to do all of the good things it was supposed to do, then it should be written into the law that rates would be controlled and/or reduced. Why shouldn't this be in the law? The insurance industry in Florida had implied this was the end result of any reform. However, we apparently took the insurance industry's word at face value. As far as I know, there were no concerted efforts by physicians to put limits on rates as we apparently believed this would come to pass with tort reform. Like manna from heaven, so to speak. The Legislature was not quite so trusting and wanted to put this into the legislation. Suddenly, the insurance industry started changing its tune. It would no longer say that tort reform would mean lower premium and it was unfair to mandate this. This was an absolute phenomenon!

How could things change in a few days? The obvious answer is that the insurance industry had no plans to lower premiums. And in fact, several companies then surfaced and announced that they had plans to raise premiums for the coming year. Amazing, isn't it?

Let me reiterate my personal position on the matter. As a physician, I have a prejudiced view of our present tort system. I think that the system has to be seriously reformed in order to bring about changes in the liability situation. I confess that I am not sure what this reform should be. I suspect it will have to be some type of no-fault insurance that is removed from an adversary system to one of proper and fair compensation for an injured party. However, at this time, I classify myself as an opponent of the present tort sytem.

The trial attorneys are both wrong and right. I think they are wrong when they say tort reform is not the answer to the liability crisis (although I have qualified my lack of suggestions as to what that reform should ultimately be). I think they are right when they say that the insurance industry will not guarantee lower liability premiums. The reason it will not is not because limits on pain and suffering or revision of joint and several liability will not lower the amount of monies lost by insurance companies, but because the insurance companies will not stabilize premiums unless they are compelled to do so.

I am an ally with the insurance industry. Several monts ago I felt confident with them on my flank and as our ally. Now I do battle with the trial attorneys, keep one eye on the insurance industry and one hand on my wallet. I have hardly got time to fight the attorneys.

H. Frank Farmer, M.D., Ph.D.
New Smyrna Beach

Warning: more lawsuits ahead, but solution in sight

During the debate over what action to take to solve the liability crisis, one simple fact seems to have been lost: the ultimate solution to the liability crisis is to prevent cases from getting to court in the first place. Far too many defensible cases are lost to a sympathetic, emotional jury that confuses recognized complications with negligence.

Physicians need only pick up a journal or attend a medical meeting to find someone counseling them about malpractice prevention. In order for a physician to decrease the odds that he will be sued, he should keep complete and legible records, be open and courteous to patients and families, and generally strive to be as perfect as possible. Even with all this emphasis on prevention and quality medical care, we are still being sued at an unprecedented rate with no end in sight. In other words, making yourself malpractice-proof just is not working.

But, there is another type of malpractice prevention: preventing the marginal or frivolous case from ever being filed, and failing that, from ever reaching a jury. Over the past year I had the opportunity to review a number of malpractice cases, a task that is guaranteed to make one a little grayer. In many of these cases I was appalled to see the trumped up charges against the doctor. Worse still were the opinions of the plaintiff's experts, opinions which if not outright perjury bordered on the ridiculous. The 1985 malpractice reform law was supposed to decrease the number of frivilous suits by requiring a 90 day notice of intent to file suit accompanied by affidavits supporting the case. Considering all the research firms and supposed experts who will be glad to write supporting a letter for a fee, the "reform" is almost laughable.

Frivolous lawsuits are like the weather: everyone talks about them but nobody seems to be able to do much about them. But that was not the case in the late 1970's. For a few years the mediation panels did a superb job of keeping marginal cases out of court. Each suit was required to be heard by a panel consisting of a doctor, attorney, and a judge. Unfortunately, the panels were declared unconstitutional. Since then medical organizations have urged the legislature to "do something about the malpractice crisis." Most of the proposed solutions dealt with changes in the tort system; reviving mediation panels was considered a lost cause. The long term solution to the liability crisis is to develop a mechanism to take the place of the mediation panels which would serve the purpose of allowing legitimate suits to be heard by a jury while keeping frivolous suits out of court.

A medical malpractice lawsuit, no matter how complicated, can be reduced to a few simple parts. The plaintiff alleges that the doctor violated the standard of care and caused him injury. The doctor uses his medical record and his testimony to defend himself. If the case could end here, it would be up to the jury to simply decide which side they believe. However, in all lawsuits each side is allowed to obtain expert testimony, although the end result as far as the jury is concerned is still the same: which experts they believe in. In borderline lawsuits the plaintiff can always find someone to testify even if he has to rent an expert from the classified section of legal journals. This "expert" may give an opinion that is completely out of the mainstream of medical practice and contrary to what the majority of doctors would say. Unfortunately, the jury has no way to know that. Ideally the jury should take a poll from a group of doctors as to whether the defendent did indeed breach the standard of care. The standard of care would in effect be established by majority opinion instead of solo opinion. The mediation panels were successful because they heard the evidence and rendered an opinion that was admissible in court, thus defining the standard of care. When the findings were in favor of the doctor, as they were in the majority of cases, many attorneys dropped the case like a hot potato.

I suggest that the standard of care be based on what the "majority" of doctors would do in similar circumstances, and that a mechanism be established that would convey this opinion to the jury. One possibility would be for county medical societies to form panels of doctors in various specialties to review and discuss each case and then render a group opinion. Either party in the suit could call witnesses and the panels' consensus would be admissible in court. Unlike the mediation panels which were mandatory, this service would be optional. How many plaintiff's attorneys would take a case to court when he knew that his one out of town expert was being refuted by a panel of 20 local doctors who agree as to the standard of care in the community? A mechanism that conveys to the jury the standard of care as practiced by most doctors in the community is the answer to keeping borderline cases locked in a file cabinet where they belong.

Lee A. Fischer, M.D.
Associate Editor
West Palm Beach

THE DADE COUNTY MEDICAL ASSOCIATION SPONSORS

MEDICAL EXPO '86

- Physicians
- Administrators
- Purchasing Agents
- Nurses
- Technicians
- Medical Managers

JOIN US FOR THE OPPORTUNITY TO SEE TOMORROW'S HEALTH CARE TODAY
NO ADMISSION CHARGE

DCMA WILL HOLD ITS QUARTERLY MEMBERSHIP MEETING AT EXPO

6:00 P.M.-RECEPTION/COMPLIMENTARY HORS D'OEUVRES 7:00 P.M.-PROGRAM

OVER ONE HUNDRED EXHIBITS FEATURING:

• PHARMACEUTICALS • LABORATORY SERVICES • MEDICAL EQUIPMENT & SUPPLIES •
• HEALTH CARE SERVICES • DIAGNOSTIC EQUIPMENT • HOSPITAL EQUIPMENT •
• COMPUTERS/SOFTWARE • INSURANCE • INVESTMENT COUNSELING •

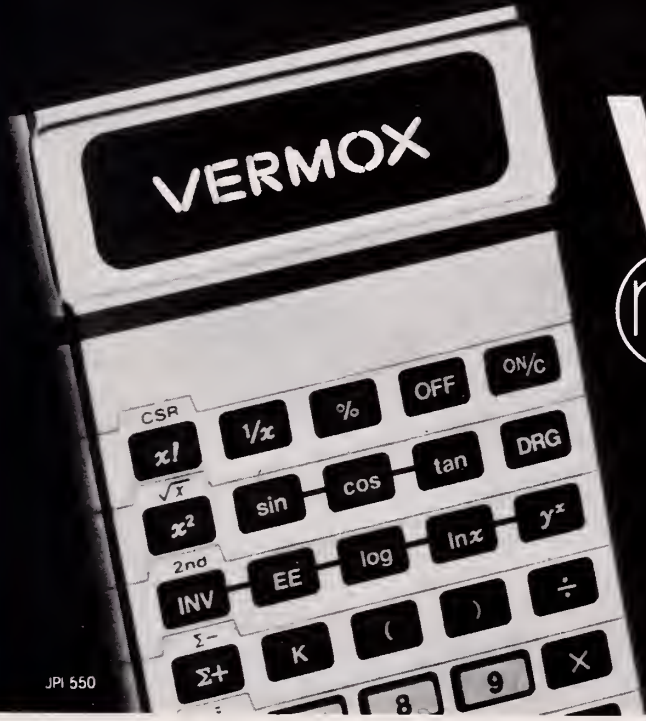
ACCREDITED SEMINARS

GUEST SPEAKERS

SEPTEMBER 2, 1986 — 11:30 A.M.-9:30 P.M.
MIAMI EXPO/CENTER — MIAMI, FL
* FREE PARKING *

FOR INFORMATION CALL 1-800-225-4342 (Out of State)
or (305) 393-9199 (In Fla.)

No need for dosage calculations...



JPI 550

VERMOX®
(mebendazole)
CHEWABLE TABLETS

JANSSEN PHARMACEUTICA
Piscataway NJ 08854-3998

© Janssen Pharmaceutica Inc. 1985

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

THE MEDICAL SYSTEM INCLUDES:
- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

ADVANTAGES
- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

INTERESTED?
For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

The ISI Software Question

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5mg Buccal/10mg Oral/25mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10mg



A letter to Medicare patients: telling it like it is

Here is a copy of a document that I have proposed to be signed by all Medicare patients admitted to our hospital. I have hopes it may help.

To My Medicare Hospital Patients:

On arrival in the hospital you will receive a copy of an information sheet entitled "An Important Message from Medicare." You should be familiar with it. You should also be familiar with its background, and an explanation of the words it contains, and of the information that it does not give you.

First off, I must tell you that I cannot give you strong assurance that your hospital bill will be paid by Medicare, even though I may be admitting you to the hospital for what I consider an emergency problem. Regardless of any implication in the "Message from Medicare," let me assure you that you will receive adequate and proper treatment of your illness or injury by both me and the hospital regardless of whether Medicare pays or not. This has always been the case, and will continue to be the case as long as we can stay in business.

Peer Review Organizations have been established by Medicare. The term "Peer Review Organization" is a misrepresentation in this case. A true peer review would involve chart evaluation by physicians experienced in a comparable practice in a similar area, who would evaluate sincerely and objectively, and with humility and insight, the care that a patient receives in the hospital, considering all of the circumstances requiring such care, and the evident medical expertise of the attending physician, and his documentation.

The Peer Review Organization is a corporation that was set up a couple of years ago to bid, in competition with other corporations in our state, for a contract with Medicare. The contract (for millions of dollars), required a commitment from the corporation that Medicare expenditures in this area would be reduced by a specified amount in many different categories. This corporation must produce the results that it contracted for, or it will lose the lucrative contract with Medicare. The corporation then hired clerks, nurses, and physicians to carry out the commitments of the corporation. Through a succession of screening mechanisms, this corporation studies hospital charts of Medicare patients throughout the state using specific guidelines with regard to justification for admission, and the intensity of care while in the hospital. Only charts of patients dangerously ill are omitted from evaluation.

Of course, there have been some patients unnecessarily admitted or kept overlong in the hospital at the behest of either the patient or the doctor, and, of course, this constitutes an inappropriate expense for Medicare. And of course, it is important to find ways to eliminate such waste. The approach currently being used, however, presumes that there are very large numbers of such Medicare abuses, and this is simply not so. Because of this invalid assumption, the PRO corporation committed itself in the contract to reduce expenses in amounts far exceeding the justifiable level, and now is having to fulfill its commitments by denying payment in many instances that are clearly justified. The PRO is declining payment in many truly appalling situations.

For example, I had a case of a feeble, totally deaf, 88-year-old man who came in the early evening to the emergency room, having fallen and fractured his knee cap. He was in much pain; the knee was too severely swollen to apply a cast right away, and his only help at home was his wife who was herself aged and barely able to take care of him without the injury. The ad-

mission was clearly necessary. I admitted him and 36 hours later when the swelling had gone down, put a cylinder cast on his leg and sent him home. PRO denied payment for the hospital admission, and I appealed the denial, and reported in detail the reasons why admission was necessary. After the appeal hearing, later, I received another letter from PRO reaffirming the denial of payment. The letter expressed sympathy for the problems of the patient, but stated that this was a "social problem," whatever that means.

We have numerous other examples clearly indicating inadequate study of the hospital chart, or inadequate practical experience on the part of the physician reviewers. Or, in many cases, guidelines that permit no exercise of judgment in the review.

This is not peer review. This is clearly the action of a corporation comitted to a certain number of dollars and cents that must be itemized as "savings," regardless of all else.

Nothing is left to the judgment of the attending physician. Two men may be admitted to the hospital with the same amount of severe chest pain. One of them turns out to have a massive heart attack, and the other has indigestion. Unless both are treated in the same intensive fashion, with the same expensive intravenous fluids, drugs, monitoring, lab studies, etc., the one who just had indigestion is found to be an unjustifiable admission. No consideration is given to the fact that the doctor who is looking at both patients is able to tell, from many past clinical experiences, and from looking at the patient, that the one with indigestion does not require all of the expensive activities in order to give him adequate protection and consideration.

As you can imagine, faced with the unreasonable criteria that we must deal with, and faced with the need to protect the hospital as far as possible from loss of payment, the hospital practicing physician has had to modify his methods of dealing with sick people. Instead of following clinical judgment as before, we now have to seriously consider what we must expect in any given situation from the PRO reviewing team when it later looks at the chart. Accordingly we now have to decline or postpone admission of patients who, in good clinical judgment, should be admitted, simply because a later reviewer, not looking at the patient, or seeing the whole scene, may decide that the patient could have gotten along all right without being admitted.

As you can imagine, this kind of activity goes seriously against the grain of all well trained physicians. It is at least as unethical to overtreat a patient as to undertreat him.

So, as you can see, this "Important Message from Medicare" is somewhat misleading. Your right to proper diagnosis and treatment, your discharge date etc., should be determined solely by your medical needs as the message says, but obviously they are affected by DRG's and PRO denial of Medicare payments.

All ethical practitioners of medicine are anxious that abuses be eliminated. At the present time the PRO is throwing the baby out with the bath water. Hospitals can stand only so much of this unjustified denial of payment. After an appeal is turned down, the hospital has no further recourse.

So, as you can see, payment of your hospital bill by Medicare has no relationship to my professional opinion or experience or judgment. Accordingly, I must hereby warn you that you may be billed for your hospital care. Having been warned, you may be held liable. If the PRO later issues a "retrospective denial", the hospital can have no reimbursement for your care except from you.

Sincerely,

Your Medicare Physician

I hereby acknowledge that I have read the above warning and understand my possible liability, if my treatment becomes classified as "non-covered services."

_____ _____

Date Patient

W. E. Manry Jr., M.D.
Lake Wales

Double standards in medical care

I recently read the article by Richard J. Feinstein, M.D., "Physician Payment Plans and Conflicts of Interst," in your May issue.

I think Dr. Feinstein echoes the sentiments of most, if not all, of the physicians who have been in practice for more than five years. The various and sundry third-party payors are establishing a new double standard in the care of patients. Those who pay for their services are certainly those who will be given the kind of attention that all of us would expect to be given in a fee-for-service situation.

On one hand, some of the HMO's have cut fees to the point where one has to seriously consider whether or not to participate in the program. We are being bombarded with various plans that mandate that we will take a lesser than usual fee-for-service.

On the other hand, nothing is being done to reduce or control overhead, particularly with regard to professional liability.

I think that in all likelihood, if things continue in the same vein as they are currently going, there will be doctors who treat patients only on a fee-for-service basis and the insurance benefits will be collected by the patient. The plastic surgeons have been doing this for many years and I suspect there will be a number of others who will be following suit in the not too distant future.

James E. Kaelin, M.D.
Jacksonville

Was surgery needed?

I read with interest the article "Severe Post-TURP Syndrome in Patient with Renal Insufficiency; Treatment with Hemofiltration" by Stephen Sandroni, M.D., that appeared in the May issue of *The Journal.* What really confused me is why a seventy-one year old man with advanced renal insufficiency i.e. BUN of 81, Creatinine of 7.6 is undergoing transuretheral prostatectomy.

Certainly more information concerning the procedure itself, i.e. length of time of pre-operative urinary drainage, size of the prostate, length of the operation, etc. certainly all play a role in the development of this syndrome. It also points out that the use of glycine solution as an irrigant does not prevent post TURP syndrome and hyponatremia does occur. I would severely question this patient's need for prostatic surgery.

R.T.E., M.D.

Progress report from retired physicians

In the Novmber, 1984 edition of the *JFMA* there appeared a letter to the editor entitled, "Consideration for the Retired Physician, a Plea."

As you may be interested in a follow-up, I take the liberty to forward the following report. At the time the administration of North Ridge General Hospital mailed a copy of the letter to each member of the active staff. The results, in conformity with the plea, were on the whole good. At present, the Senior Physicians Associates AMI/North Ridge are a group of 179 retired physicians who during the past year have participated in the following activities:

1. CME Meetings of the Active Staff.

2. Monthly CME Meetings sponsored by the group on the last Friday of each month, except the summer months and the following presentations:
 a. Economics in Healthcare Delivery.
 b. The Role of the Clinical Pharmacist in a General Hospital.
 c. Anesthesia, Then and Now.
 d. Cardiac Catheterization, Why, When and How.
 e. Thirty Years of Operating on the Human Heart.
 f. Common Pulmonary Afflictions in South Florida.
 g. Stress, Distress and the Rehabilitaiton of the Adrenal Medulla.

3. A feature, "A Memory I Cherish" brought several members to the lectern who spoke on:
 a. A laryngectomy 58 years ago, the patient still alive and well.
 b. A pain measuring device, 20 years ago.
 c. Ann Bancroft learning about blind children in preparation for her role as Anne Sullivan.
 d. The conversion of the Coroner System to the Medical Examiner System in the U.S. Virgin Islands.

4. Doctors-Spouses meetings proved to be popular. Educational and more mundane topics were featured:
 a. Wear, Tear and Care of our Skin.
 b. Muscular Relaxation and Stress.
 c. Estate Matters.
 d. Life Care Centers.

The gatherings afforded and still afford the retired physician a means of communication to express his bewilderment as to the development of the profession as he knew it into a "Health Care Industry" with himself as a "Consumer" while he still feels and thinks as a "Provider."

With great astonishment he follows the daily newspapers and full-page advertisements of corporate giants that have taken over hospitals and HMO's and the million dollar figures bandied about.

Hopefully the AMI/North Ridge Senior Physicians Associates will be able to issue a progress report two years hence.

Herman E. Mautner, M.D.
Chairman, Activities Committee
AMI/North Ridge General Hospital
Ft. Lauderdale

FIFTH ANNUAL CARDIOLOGY UPDATE '86

OCTOBER 17-19, 1986

SPONSORED BY THE:
SOUTHWEST FLORIDA HEART INSTITUTE
OF FORT MYERS COMMUNITY HOSPITAL

PROGRAM DIRECTORS:
HARVEY TRITEL, M.D., F.A.C.C.
RICHARD CHAZAL, M.D., F.A.C.C.

PRESENTED AT THE
SUNDIAL BEACH & TENNIS RESORT
SANIBEL ISLAND, FLORIDA

PROGRAM

FRIDAY, OCTOBER 17TH

"Myocardial Protection"
Robert Schlant, M.D.

"The Role of Spasm in Ischemic Heart Disease"
Michael Assey, M.D.

"Stratifying the Risk of Patients' Post-Myocardial Infarction"
Steven Scheidt, M.D.

"Calcium Blockers vs. Beta Blockers for Angina and Hypertension"
William Frishman, M.D.

"Streptokinase for the Acute MI"
Bill Rodgers, M.D.

Panel Discussion—"The Role of Invasive Procedures in the Acute MI"

SATURDAY, OCTOBER 18TH

Coffee & Danish—Richard Chazal, M.D.

"Emerging Concepts of Hypertension Therapy"
Julien L. Seifter, M.D.

"The Clinical Pharmacology of Beta Blockers in the Treatment of Complicated Hypertension"
David Lowenthal, M.D.

"New Anti-Arrythmics"
Leonard Dreifus, M.D.

"Congestive Heart Failure and the Role of Afterload Reduction"
James Spann, M.D.

"The Role of Amrinone in the Treatment of Congestive Heart Failure"
Carl Webber, M.D.

"Silent Ischemia"
Stephen Glasser, M.D.

GUEST LECTURE—"DIET AND YOUR HEALTH"
Vijaya C. Ratnesar, M.D.

GUEST LECTURE—"STRESS MANAGEMENT —A BRIEF OVERVIEW"

SUNDAY, OCTOBER 19TH

BREAKFAST—Harvey Tritel, M.D.

"The Role of Digitalis in the Cardiac Patient"
Nancy Flowers, M.D.

"Sudden Death"
Albert DelNegro, M.D.

"Expanding Indications for Angioplasty —Including Acute MI"
David O. Williams, M.D.

"Indications for Pacemakers"
William Miles, M.D.

"Lipids and Arteriosclerosis—An Overview"
Peter O. Kwiterovich, Jr., M.D.

PANEL DISCUSSION—"The Future Direction of Cardiology"

APPLICATION FOR ENROLLMENT

FIFTH ANNUAL CARDIOLOGY UPDATE '86

OCTOBER 17-19, 1986

Sanibel Island, Florida

PHYSICIANS: $240.00
NURSES: $ 90.00
PHYSICIANS ASSISTANTS: $ 90.00

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____

TYPE OF PRACTICE _____

Check made payable to the Southwest Florida Medical Foundation should accompany this enrollment application and be forwarded to: Registration Secretary, Fort Myers Community Hospital, 3785 Evans Avenue, Fort Myers, Florida 33901

For accommodations call Sundial Beach & Tennis Resort—800/282-3405. Special rates are available for Cardiology Update attendees.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
JULY 1986, Vol. 73, No. 7

Survey of raccoon hunters for rabies antibody titers: pilot study

David Black, D.V.M., M.S., M.D., and Tadeusz J. Wiktor, D.V.M.

ABSTRACT: Thirty individuals, all of whom either hunt, commercially skin, or eat raccoon meat, were designated as a study group. Twenty-nine individuals who resided in the same region as the study group and hunt and consume wild game other than raccoons were designated as a control group. Blood samples were obtained from all individuals and examined for serum neutralizing activity against rabies employing a rapid flourescent focus inhibition test. Low levels of serums neutralizing activity were detected in five of the 30 members of the study group. No members of the control group had detectable antibody titers. Four of five individuals with antibody titers hunted foxes, all hunted raccoons, one consumed raccoons, and two skinned raccoons. Additional studies are proposed to further define the specificity of these antibodies.

The Authors
DAVID BLACK, D.V.M., M.S., M.D.
TADEUSZ J. WIKTOR, D.V.M.
Dr. Black is a senior resident in Family Practice at the University of Florida College of Medicine, JHMHC, Gainesville, and will be entering practice in Gainesville, in July, 1986, while Dr. Wiktor is a research scientist with Wistar Institute, Philadelphia, Pennsylvania.

Approximately 25,000 people are treated per year in the United States for exposure to animals thought to be rabid. Dogs are the primary source of reported exposures.[1] In spite of this high number of potential exposures, an average of only two cases of human rabies, both fatal, have been reported annually for the past 20 years in the United States and its territories. During this same period 7,211 laboratory confirmed cases of animal rabies were reported. Florida, where rabies is enzootic in the wild raccoon population, accounted for 116 of these cases. The number of cases in Florida according to species were as follows: dogs 1, cats 7, other domestic animals 1, skunks 3, bats 17, raccoons 79, fox 7 and other wild animals 1.[2] A statewide survey by Bigler[3] in 1972-73 demonstrated that a population of randomly trapped "normal" animals which consisted of 103 raccoons, 93 opossums, and 12 skunks were free of rabies virus. Of this group 4.4% of the raccoons and 1.5% of the opossums were positive for rabies virus neutralizing antibody. During an epizootic, the rabies seropositive rate in "normal" animals increased up to 18% in raccoons (n-106) with 7% actually having rabies virus identified in nervous tissue.

Rabies except for very few exceptions has been considered uniformly fatal in humans who are exposed through an animal bite and who have not been appropriately treated. It has been established that fatal exposure in humans may also occur through other routes. Reports include aerosol exposure to infected bats while spelunking[4] or through a laboratory accident[5] as well as human to human transmission via cornea transplantation.[6] Controlled studies of laboratory animals as well as studies of wild animals reveal the natural history of rabies to be more complex than exposure, disease and death. Prolonged asymptomatic carrier states as well as recovery from

subclinical infection with production of antibodies occur in mammals and birds. Ingestion of infected material accounts for a route of inoculation not described in man.[7,8] The species which have been studied include raccoons,[3] cattle in regions infested with vampire bats,[9] swine,[10] fox,[11] vampire bats,[12] frugiverous bats[11] as well as predatory and non-predatory birds.[13]

Subsistence, recreational, and commercial hunting attracts many participants in rural Florida. Some place themselves at risk to contact rabies through their proclivity toward certain activities. Some individuals have become involved in the commercial hunting of raccoons, an animal which accounts for 70-80% of reported rabies in Florida. They hunt, trap, shoot or club many hundreds of raccoons in a year, skinning the carcasses without taking protective precautions. They sell the skins to commercial dealers and the meat to indigents. Another population hunts raccoons along with other animals to add protein to their diet. They typically do not contact as many animals in a year as the commercial hunter but in contrast to the commercial hunter consume the animal. Another population will only be involved in kitchen preparation of and consuming raccoons. These subpopulations, combined as a group, allowed the opportunity to evaluate through virus neutralization studies the possibility of subclinical exposure to rabies in a population at risk to contact the disease. This group could then be compared to a group who reside in the same region, with similar lifestyles, except for the relative risk of rabies exposure.

Methods and materials • The study was based in rural northwest peninsular Florida where the University of Florida Department of Community Health and Family Medicine operates rural clinics. Individuals were placed in the study group if they had experience hunting, commercially skinning, preparing for consumption, or consuming raccoons. These individuals were found through random inquiry at a health fair, response to a newspaper article describing the project, advertising in an ethnic restaurant window, and word of mouth. The investigator generally traveled to a site remote from the clinic to collect samples. Individuals were paid travel expenses to offer samples but were only informed of this opportunity after sample collection. No monetary inducement for participation was implied in verbal or written description of the project. The control group consisted of individuals who claimed no contact of any kind with raccoons but lived or worked in the same community as the study group. Approximately half the control samples were collected in the clinic, the others at sites in the community.

Each participant was asked a standard set of questions to determine if he/she had certain types of exposure to selected wild species of animals. Skinning was defined as removing the hides of raccoons on a commercial basis for sale of products, not for personal use. Some individuals estimated the number of raccoons they had skinned in the past year, years, or lifetime. Individuals were also asked to add other species of animals with which they had contact. Individuals who claimed exposure to rabid animals, who had been treated for such exposure, or who had been vaccinated against rabies were eliminated from the study for statistical purposes. All participants, or guardians of participants, signed an informed consent for participation in research which had been approved by the University of Florida Health Center Institutional Review Board.

Blood samples were collected by venipuncture. The serum was collected and stored by freezing. Samples were shipped under dry ice in two batches to the Wistar Institute, Philadelphia, Pa., for analysis by a rapid fluorescent focus inhibition test (RFFIT).[14] Virus neutralization titers were reported as 0.03 IU/ml, being the lowest level of serum neutralization which could be detected. Any serum with neutralizing activity was analyzed a second time, both result being reported ($\geq$ 0.03 IU/ml were considered positive for purposes of statistical analysis).

Data from the survey forms and the serum neutralization results were tabulated according to defined groups. Responses to questions and to the presence or absence of serum neutralization were considered positive or negative. Based on this binomial data, an odds ratio and 95% confidence interval was calculated[15,16] to compare the study and control groups.

Results • Table 1 is a summary of field contact (hunting and associated activity, and/or skinning of raccoons) with each species of animal. There is a difference at the $p < 0.05$ level for eight of the 13 species listed (raccoon, skunk, oppossum, fox, deer, turkey, quail, owl) with the study group having more contact. Kitchen preparation and consumption of meats from various animal species followed approximately the same pattern with individuals in the study group having been involved in this activity more than the control group. Five individuals with titers > .03 were found in the study group, none in the control group. This is significant at the $p < .05$ level with a 95% confidence interval of nearly zero and 0.78.

Individuals with positive serum included RC (0.11 IU/ml) who hunts, kitchen prepares, and consumes raccoons; JQ (0.03 IU/ml) who claims only hunting contact with raccoons; JM (0.03 IU/ml) who hunts and consumes raccoons; DH (0.11 DIU/ml) and RH (0.03 IU/ml) who both hunt and skin raccoons (DH skinned a lifetime total of 200 raccoons, RH a lifetime total of 800 raccoons). All but JM had field contact with foxes. All other game contacts were typical for their group.

Three individuals who had been vaccinated for rabies between ten and 15 years ago two prophylac-

Table 1. — Study Group vs Control Group. A Comparison of Positive Responses for Hunting, Skinning, or Field Contact with Selected Species of Wild Animals.

	Study (n = 30)	Control (n = 29)	Odds Ratio Point Estimate	Point Estimate 95% Confidence Interval	P Value
Raccoon	23	0	10^9	(16.9, 10^9)*	<.05
Bat	4	0	10^9	(0.67, 10^9)*	NS**
Turtle	1	0	10^9	(0.02, 10^9)*	NS**
Opossum	15	1	28	(3.5, 1219.5)	<.05
Fox	14	1	24.5	(3, 1071.8)	<.05
Quail	19	4	10.8	(2.6, 51.7)	<.05
Turkey	22	6	10.5	(2.8, 42.6)	<.05
Skunk	8	1	10.2	(1.2, 467.5)	<.05
Squirrel	6	1	7.0	(0.7, 333.2)	NS**
Hawk	6	1	7.0	(0.7, 333.2)	NS**
Owl	8	2	4.9	(0.8, 50.8)	NS**
Deer	22	11	4.5	(1.3, 15.8)	<.05
Bear	2	1	2	(0.1, 122.2)	NS**

*10^9 = bound limit due to 0
** = not significant, p >.05

tically, one secondary to a dog bite) had serum submitted for analysis. One was a veterinarian who had no known contact with rabid animals but had handled all species of animals listed in the questionnaire; another was a veterinarian who had significant bat contact through caving; the third had kitchen prepared and consumed raccoon as well as other game for many years. None of them had rabies virus neutralizing antibody in serum. Their responses to survey questions and serology results were not included for statistical purposes.

Discussion • Rabies antibody responses in humans have been studied as part of rabies vaccine development. Prevaccination serum titers of individuals who claim no prior exposure to rabies antigen through animal exposure or vaccination have been reported in a few instances. In only one report were positive titers described. Six percent of 230 individuals evaluated with mouse inoculation studies were reported as positive; no explanation was offered.[17] The other studies employed RFFIT with no positive samples in groups of 100[18] and 75.[19] Peak titers obtained from human diploid strain vaccine given intradermally range from 1.0-7.0 IU/ml.[20,21] Titers reported one year postvaccination in American studies typically range from 0.5-1.6 IU/ml with some Peace Corp volunteers being as low as 0.10 IU/ml.[20,21]

The titers reported here are low, three being at the lowest level of detection. They are, however, in the range of titers reported for individuals one year postvaccination. They were found only in individuals with extensive wildlife contact including raccoons and fox which constitute greater than 80% of rabies cases in Florida. Based on the profile of individuals with serum neutralizing activity, this exposure appears to be through field exposure not controlled kitchen exposure or consumption. One could postulate that those individuals exposed in the field contacted infected material with cut or abraded skin and became inoculated with inactivated virus or a subclinical dose of rabies virus.

This is the first study which evaluates the presence of neutralizing activity against rabies in people with a high probability of exposure to the disease and compares them to indviduals with similar lifestyles except for the predicted risk of exposure. Many explanations can be offered for the presence of serum neutralizing activity in the study group. They include nonspecific neutralizing activity which may occur at low titers, cross reactivity with rabies associated or other viruses, alternative disease manifestation, exposure to an inoculum of virus which was adequate to impart low-level immunity but not disease, exposure to an attenuated strain of rabies, or even subclinical rabies with recovery. Vaccination of members of the study group and monitoring of titers to evaluate for amnestic or primary response to the rabies antigen would be useful in determining the specificity of titers described in this study. If this could not be done, periodic evaluation of titers in these individuals would be a less desirable alternative. More extensive studies of the population at risk are being considered.

Acknowledgments

The authors thank Ms. S. Hendricks, Drs. L. and S. Stoddard, and Dr. L. Rooks without whom this study could not have been performed.

References

1. ACIP: Rabies Prevention-United States, MMWR 33(28):393-402, 1984
2. Parham, G.L.: Rabies in the United States, 1981, MMWR 32(155):3355-3755, 1983.
3. Bigler, W.J.; McLean, R.G., and Tervino, H.A. Epizootiologic Aspects of Raccoon Rabies in Florida, Am J Epidemiol 98(5):326-335, 1973.
4. Winkler, W.G.; Fashinell, T.R.; Leffingwell, L., et al: Airborne Rabies Transmission in Laboratory Worker, JAMA 226(10):1219-1221, 1973.
5. Irons, J.V.; Eads, R.B.; Grimes, J.R., and Conklin, A.: Public Health Importance of Bats, Texas Rep. Biol. Med. 15:292-298, 1957.
6. Human to Human Transmission of Rabies via a Corneal Transplant, France, MMWR 29(3):25-26, 1980.
7. Soave, O.: Transmission of Rabies to Mice by Ingestion of Infected Tissue, Am. J. Vet. Res. 27(116):44-46, 1966.
8. Correa-Giron, E.P.; Allen R., and Sulkin, S.E.: Infectivity and Pathogenesis of Rabies Virus Administered Orally, Am J. Epidemiol. 91(2):203-215, 1970.
9. Baer, G.M.: Bovine Paralytic Rabies and Rabies in the Vampire Bat, in The Natural History of Rabies, vol. 2, Baer, G.M., ed., New York: Academic Press, 1975, pp. 155-174
10. Baer, G.M. and Olson, H.R.: Recovery of Pigs from Rabies, J. Am. Vet. Med. Assoc. 160:1127-1128, 1972.
11. Sikes, R.K.: Pathogenesis of Rabies in Wildlife, I. Comparative Effect of Varying Doses of Rabies Virus Inoculated into Foxes and Skunks, Am. J. Vet. Res. 23:1041-1047, 1962.
12. Burns, K.F.; Farinacci, C.J., and Murnome, T.G.: Insectivorous Bats Naturally Infected with Rabies in Southwestern United States, Am. J. Pub. Health 46:1089-1097, 1956.
13. Gough, P.M. and Jorgenson, R.D. Rabies Antibodies in Sera of Wild Birds, J. Wildl. Dis. 12:392-395, 1976.
14. Wiktor, T.J.; Macfarlon, R.I.; Foggin, C.M., and Koprowski, H.: Antigenic Analysis of Rabies and Mokola Virus from Zimbabwe Using Monoclonal Antibodies, Dev. Biol. Stan. 57:199-211, 1984
15. Thomas, D.G.: Exact Limits for Odds Ration in a 2x2 Table, Applied Stat. 20(1):105-110, 1971.
16. Thomas, D.G. and Gart, J.J.: Table of Exact Confidence Limits for Differences and Ratios of Two Proportions and Their Odds Ratios, J. Am. Stat. Assoc. 72(357):73-76, 1977.
17. Ruegsegger, J.M.; Black, J., and Sharpless, G.R.: Primary Antirabies Immunization of Man with HEP Flury Virus Vaccine, Am. J. Pub. Health 51(5):706-716, 1961.
18. Smith, J.S.; Yager, P.A., and Baer, G.M.: Rapid Reproductible Test for Determining Rabies Neutralizing Antibody, Bull WHO 48:535-541, 1973.
19. Burridge, M.J.; Baer, G.M.; Sumner, J.W., and Sussman, O.: Intradermal Immunization with Human Diploid Cell Rabies Vaccine, JAMA 248(13):1611-1614, 1982.
20. Burridge, M.J.; Sumner, J.W., and Baer, G.M.: Intradermal Immunization with Human Diploid Cell Rabies Vaccine: Serologic and Clinical Responses of Immunized Persons to Intradermal Booster Vaccination, Am. J. Pub. Health 74(5):503-505, 1984
21. Field Evaluation of Pre-Exposure Use of Human Diploid Cell Rabies Vaccine, MMWR 32(46):601-603, 1983.

- Dr. Black, Department of Community Health and Family Medicine, University of Florida College of Medicine, JHMHC, Box J-222, Gainesville 32610.

"Sting" of Puss Caterpillar, *Megalopyge opercularis* (Lepidoptera: Megalopygidae): first report of cases from Florida and review of literature

Rif S. El-Mallakh, M.D., Donald L. Baumgartner, M.S., and Naguib Fares, M.D.

ABSTRACT: The puss caterpillar Megalopyge opercularis, is considered one of the most serious poisonous pest caterpillars. Its "sting" usually has a characteristic clinical presentation and can be diagnosed without examination of the caterpillar. However, stings are probably underdiagnosed because of lack of physician awareness. We report three cases from Florida, the first reported in this state, and review the literature regarding this insect.

The Authors
RIF S. EL-MALLAKH, M.D.
DONALD L. BAUMGARTNER, M.S.
NAGUIB FARES, M.D.
Dr. El-Mallakh is with the Department of Neurology, University of Connecticut Health Center, Farmington, Connecticut, while Dr. Baumgartner is with the Norhtwest Mosquito Abatement District, Wheeling, Illinois, and Dr. Fares is in private practice in Hudson.

Immature Lepidoptera (Insecta) of 150 species in 15 families worldwide have been reported to cause irritating dermatitis, severe pain or a variety of systemic manifestations upon contact with human skin.[1,2] These symptoms may be due to urticating hairs and/or spines the larvae possess as a means of defense. Although the majority of these medically-important insects are tropical,[3] approximately 50 species among eight families are known to occur in North America.

One of the most seriously poisonous pest caterpillars in the United States is the puss caterpillar, *Megalopyge opercularis*, Smith and Abbot (Megalopygidae) (Fig. 1), also known from various regions as the "woolly worm," "woolly slug," "opossum bug," "tree asp," "Italian asp," and "el perrito" (Spanish for "little dog").[4] In old scientific literature it has been referred to as *M. subcitrina* Walker. Currently 20 species of this family are reported to produce clinical symptoms in humans.[2] Typical symptoms of contact with *M. opercularis* include intense local burning pain which radiates proximally, erythema with local edema, grid-like hemorrhagic papular lesion, formation of whitish papules acutely, and lymphadenopathy, all of which may persist several days in the absence of treatment.[4-7]

A general herbivore,[4,7] *M. opercularis* has a wide southeastern distribution from Maryland to Mexico with records specifically from Missouri, Maryland, Virginia, North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, and Texas,[8] as well as a single specimen from Ithaca, New York[9] (Fig. 2). Although caterpillar-human interactions are very common throughout its range, clinical cases are rarely documented, probably due to physicians' inability to identify the etiologic agent.[6] Published

reports of *M. opercularis* stings are known from Maryland, North Carolina, Arkansas, Georgia, Louisiana, and Texas; epidemics have occured in Oklahoma, South Carolina, and Virginia (Table 1 and Fig. 2).[7,10] We herein report three new cases from Florida, the first from this state, along with a summary of previously published cases in the United States.

Case reports ● Case 1. — On September 9, 1985 a 65-year-old woman from Pasco County presented with a bilateral skin rash and forearm pain. The patient reported that while gardening the day prior to presentation she noticed two caterpillars stuck on each of her forearms. Within minutes a rash appeared accompanied by shooting pains up the arms which increased with intensity. General malaise followed. On examination she was in no distress with blood pressure of 150/80 mmHg, pulse 75/minute, and temperature 98° F. The lesions, identical on both forearms, were eliptical and erythematous with a central area measuring 2 × 0.5 cm surrounded by a wide area of flare and edema. No lymph nodes were palpable. She was treated with triamcinolone acetonide (Kenalog) 40 mg intramuscular injection and topical desoximetasone cream 0.1%. She was asymptomatic by the next day. On follow-up three days later the skin lesions appeared more characteristic (Fig. 3) as multiple nonblanching, hemorrhagic, pinpoint papules in a grid-like pattern the same size as the caterpillar (1.5 × 0.5 cm). At a later time numerous larvae and cocoons of *M. opercularis* were collected from a badly defoliated Schilling plant in the patient's garden. Voucher specimens of the larvae have been deposited at the National Museum of Natural History (Smithsonian Institution), Washington, D.C.

Case 2. — On September 7, 1985 a 31-year-old woman from Pasco County presented with severe right arm pain. The previous day she noticed a "worm" creeping on her right arm while lounging in her yard. There was an immediate erythematous skin reaction followed by severe local pain which extended proximally within an hour. She brought the caterpillar with her. Examination revealed blood pressure 110/74 mmHg, pulse 68/minute, and temperature of 98.8°F. She had an eliptical two cm long erythematous lesion surrounded by a wider area of edema. No lymph nodes were palpable. Treatment consisted of triamcinalone acetonide 40 mg intramuscular injection and topical desoximetasone cream 0.1%. She was asymptomatic within 24 hours. The offending caterpillar brought in by the patient was subsequently identified as *M. opercularis*.

Case 3. — On September 14, 1985 a 17-year-old male of Pasco County was mowing his lawn without a shirt. He noted a caterpillar on his upper chest after brushing against a tree. A skin rash quickly developed followed by onset of moderate to severe chest pain which lasted four days. Medical attention was not sought at the time. During an unrelated visit an *M. opercularis* caterpillar in the office was recognized as being similar to that which he had encountered.

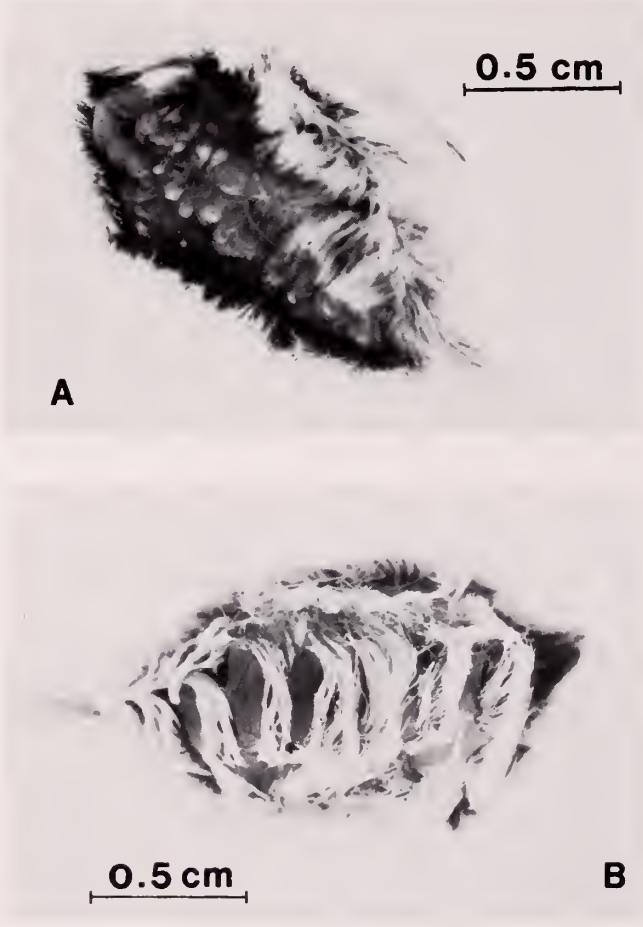


Fig. 1. — Immature Megalopyge opercularis (Lepidoptera: Megalopygidae) fifth instar, (A) venteral view; (B) dorsal view. (Photographs by Thomas Koczera, Department of Biomedical Communication, University of Connecticut Health Center).

Discussion ● *M. opercularis* is a relatively large (2-3 cm long during last instar), hairy, conspicuous white and brown caterpillar (Fig. 1). The adult moth is small and dull light brown. It is widely distributed throughout the southeastern United States (Fig. 2). Populations fluctuate yearly depending on Dipteran (fly) and Hymenopteran (wasp) parasites which are their only natural controls.[4-11] The caterpillar is a general herbivore and is prevalent on a wide variety of plants including elm, hackberry, oak, willow, mulberry, sugarberry, sycamore, and plum, and less frequently on rose, geranium, corn, citrus trees, and now the Schilling bush.[4,6,11-15] At times this pest is numerous enough to completely defoliate trees.[4] They are said to be common in flower gardens and orchards.[6,16] Citrus infestations are known from Texas[17] and Florida[18]

Much of *M. opercularis* biology has been investigated.[4,15,19] Adults emerge between March and June, quickly mate, oviposit, and die within nine days. From 300 to 600 eggs are laid by a single female. Larvae (Fig. 1) require 30-60 days to pass through five instars. Mature caterpillars usually pupate in September but may pupate as late as November and overwinter in this stage. In northern latitudes *M. opercularis* has only one generation per year but two generations occur in the southern latitudes, e.g., Florida or Lousiana.[12,15,18] Various techniques have been devised to rear adults in the laboratory.[15,19,20]

Only the caterpillars possess the defensive short, hollow spines which are laid down in six parallel

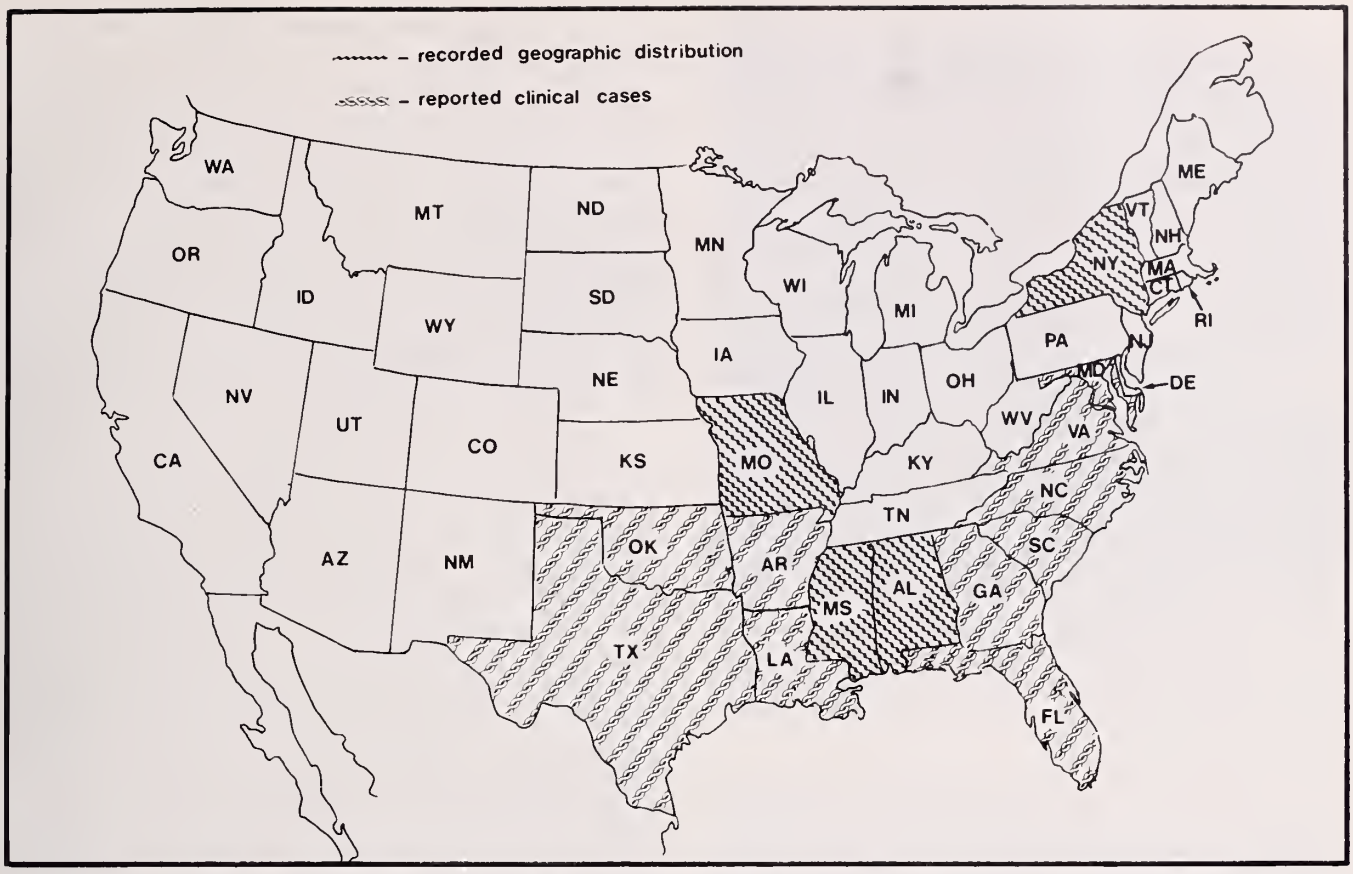


Fig. 2. — Geographic distribution of Megalopyge opercularis (all highlighted states) and states from which clinical cases and/or epidemics of M. operculais have been reported (chain line). The cases in this report are the first reported from Florida.

longitudinal rows among the inoffensive long ornamental hairs (Fig. 4). All larval instars are capable of stinging but toxicity increases with instar advance, i.e., increased size,[5,19] and only the large final instar has been reported to cause clinical disease, accounting for the fact that most stings occur in the fall (Table 1). Cocoons and adults are harmless. The spines are arranged in clusters in a grid-like pattern over the dorsal surface of the caterpillar (Fig. 4), which accounts for the typical lesions appearing as grid-like papules or hemmorhagic maculae (Fig. 3). It is believed that a single cell at the base of each spine manufactures a venom which is injected into the skin through the body of the hollow spine.[5] Foot[5] and Davidson[19] elucidated the morphology, histology, and development of the stinging mechanism. The chemical nature of the venom is unknown but it has been hypothesized to be either a protein[5] or a substance that conjugates with proteins.[21] Histamine concentration in the venom is very low and acetylcholine is undetectable.[22]

When humans encounter *M. opercularis* the resulting clinical presentation is monotonously characteristic (Table 1). Often stings occur in the fall months when the caterpillars are mature and set out to seek suitable sites for pupation. Contact usually occurs over an extremity but in some cases is truncal.



Fig. 3. — Detail of sting site revealing typical grid-like hemorrhagic lesions. Reprinted with permission from McGovern et al.[8]



Fig. 4. — Dorsal surface of M. opercularis with the long ornamental hairs removed to reveal the clusters of poison-bearing hollow spines arranged in a grid-like pattern (original photograph by F. W. Schmidt from Micks;[12] reprinted with permission).

Invariably there is severe instantaneous local pain which is often accompanied by an irrepressible itch. Within ten to 15 minutes local erythema, swelling, and severe proximally-radiating pains develop. The pain may be severe enough to cause pseudoparalysis. In approximately 35% of patients lymphadenopathy of the affected limb may develop within hours or days.[8] Other symptoms which may occur but are infrequent include restlessness, muscle cramps, itching, numbness, headaches, fever, nausea, vomiting, tachycardia, hypotension, and convulsions. Head and neck stings may be more dangerous. Hospitalization has been reported in young children exhibiting a severe reaction to the sting.[8] No deaths have been reported. The site of contact will often bear a grid-like pattern of hemmorrhagic papular lesions. These may be masked by more generalized erythema on initial presentation and are most easily seen in the convalescing patient. With or without treatment patients are often asymptomatic in four to five days.

There is no specific therapy; treatment is aimed at relieving pain and reducing inflammation. Acetylsalicylic acid[8,19] and calamine lotion[6] are ineffective in this regard. Early reports of the usefulness of intravenous calcium gluconate[12] have never been reexamined. Other common approaches include oral or parenteral diphenhydramine (Benadryl),[8,9,12] and oral or parenteral meperidine.[9,13] The use of parenteral corticosteroids has not been previously reported. The two patients in this report who received intramuscular triamcinalone were asymptomatic within 48 hours of the sting and 24 hours of treatment, whereas the untreated patient was symptomatic for approximately four days. This suggests that a one-time parenteral dose of corticosteroid may shorten the duration of symptoms.

Since the caterpillar is endemic in Florida and a pest to citrus growers and harvesters,[17,18,23] it is likely

Table 1. — Summary of Published Cases of Megalopyge opercularis Stings.*

Date	Location**	Sex	Age	Site	Reaction	Ref
1922	LA	M		Hand	Pain, papules, nausea, numbness	16
10/1936	GA	M		Hand	Pain	23
10/1936	GA	F		Finger	Pain, erythema, white papules, tachycardia, lymphadenitis	23
8/1941	MD	M	46	Neck	Pain, erythema, white papules, headache, muscle cramps, itching	6
10-11/1951	TX	F	26	Foot	Pain, erythema, itching, numbness, hypotension, bradycardia	12
10-11/1951	TX	M	9	Hand	Pain, erythema, nausea, vomiting	12
10-11/1951	TX	F	58	Hand	Pain, lymphadenitis, dizziness	12
10-11/1951	TX	F	33	Face	Pain, eryhthema, headache, nausea, swollen nose	12
10-11/1951	TX	M,F	6-63	Hand-8 Leg-4, Neck-2	Pain, erythema, swelling, lymphadenitis, nausea, vomiting	12
Summer of 1958	TX	2130	cases	Various	Pain 98%, swelling 92%, headache 29%, lymphadenitis 32%, shock 5%, convulsion 0.5%	8
9/1962	NC	F	10	Wrist	Pain, erythema, swelling, fever	9
9/1962	NC	M	6	Arm	Pain, erythema, white papules, lymphadenitis, weak, pale	9
9/1962	NC	F	10	Fingers	Pain, erythema, swelling	9
7/1973	AR	F	80	Hand	Pain, erythema, edema	13

*Epidemics withour details are excluded[7,10]
**Abbreviations are those used by the United States Postal Service

that caterpillar stings are a relatively common occurrence. Clinical effects are severe enough that a large proportion of patients are likely to seek medical attention. However, proper diagnosis is hampered by lack of physician awareness and improper descriptions of the caterpillar by patients. Patient history, symptoms, and examination should lead the physician to make the correct diagnosis even without examination of the caterpillar. Effective symptomatic treatment can be achieved with a variety of approaches but there is evidence that a one-time parenteral dose of a corticosteroid may shorten the course of the reaction.

References

1. Henwood, B.P. and MacDonald, D.M.: Caterpillar Dermatitis, Clinical Exp. Derm. 8:77-93, 1983.
2. Alexander, J.O.D.: Arthropods and Human Skin, Springer-Verlag: N.Y., 1984.
3. Tejada, A.: Lepidopterismo y Erucismo en la Hoya del Hullaga, Revta. Soc. Peruana Derm. 2:143-148, 1968.
4. Bishopp, F.C.: Puss Caterpillar and Effects of Its Sting on Man, U.S.D.A. Dept. Circ. 288:1-14, 1923.
5. Foot, N.C.: Pathology of Dermatitis Caused by *Megalopyge opercularis*, Texan Caterpillar, J. Exp. Med. 35:737-754, 1922.
6. Lucas, T.L.: Poisoning by *Megalopyge opercularis* (Puss Caterpillar), J.A.M.A. 119:877-880, 1942.
7. Anonymous: Puss Caterpillars, A New Problem for PCO's, Pest Control 29:1S-18, 1961.
8. McGovern, J.P.; Barkin, G.D.; McElhenney, T.R., and Wende, R.: *Megalopyge opercularis*. Observations of Its Life History, Natural History of Its Sting in Man, and Report of Epidemic, J.A.M.A. 175:1155-1158, 1961.
9. McMillan, C.W. and Purcell, W.R.: Hazards to Health — Puss Caterpillar, Alias Woolly Slug, N. England J. M. 271:147-149, 1964
10. Scott, H.G.: Stinging Caterpillars, Pest Control 32:24-25, 1964
11. Flitters, N.E.: Stinging Caterpillars ("Asps") in lower Rio Grande Valley, Rio Grande Valley Horticul. Soc. J. 14 189-199, 1960.
12. Micks, D.W.: Clinical Effects of Sting of Puss Caterpillar (*Megalopyge opercularis* S. & A.) on Man, Texas Rep. Biol. Med. 10:399-405, 1952.
13. Daly, J.J. and Derrick, B.L.: Puss Caterpillar Sting in Arkansas, South M J 68:893-894, 1975.
14. Neck, R.W.: Lepidopteran Foodplant Records from Texas, J. Res Lepidop. 15:75-82, 1976.
15. Khalaf, K.T.: Biology of Puss Caterpillar and Its Ichneumonid Parasite, Loyola University Press: Louisiana, 1975.
16. Beyer, G.E.: Urticating and Poisonous Caterpillars, Quart. Bull. Louisiana State Board Health 13.161-168, 1922.
17. Dean, H.A. and Schuster, M.F.: Puss Caterpillars on Citrus, Rio Grande Valley Horticul. Soc. J. 17:112-115, 1963
18. Watson, J.R. and Berger, E.W.: Citrus Insects and Their Control, Fla Agricul. Entomol. Bull. 88, 1937.
19. Davidson, F.F.: Biology of Laboratory-Reared *Megalopyge opercularis* Sm. & Abb. Morphology and Histology of Stinging Mechanism of Larvae, Texas J. Sci. 19:258-274, 1967.
20. Micks, D.W.: Laboratory Rearing of Puss Caterpillar, with Notes on Incidence of parasitism, J. Econ. Entomol. 49:37-39, 1956.
21. Gilmer, P.M.: Comparative Study of Poison Apparatus of Certain Lepidopterous Larvae, Ann. Ent. Soc. Amer. 18:203-239, 1925.
22. Valle, J.R.; Picarelli, Z.P., and Prado, J.L.: Histamine Content and Pharmacological Properties of Crude Extracts from Setae of Urticating Caterpillars, Arch. Int. Pharmacodyn. Ther. 98:324-334, 1954
23. Goodwin, T.; Krafka, J. Jr., and Mulherin, P.: Caterpillar Bite (*Megalopyge opercularis*), Report of Cases, J. Med. Assoc. Georgia 26:157, 1937.

● Dr. Fares, 8221 State Road 52, Hudson 33567.

Adenocarcinoma of small intestine (25 year review — Roswell Park)

Donald F. Temple, M.D., F.A.C.S.

ABSTRACT: Twenty-three patients with adenocarcinoma of the small intestine form the basis for this review. Common symptomatology in these patients included weight loss, nausea and vomiting, anemia and intestinal obstruction. No set protocol of management combining surgery, chemotherapy and radiation is presently available.

Surgical extirpation is the mainstay in the management of these lesions. The longest surviving patients are those with duodenal lesions treated with extensive pancreaticoduodenectomy during their first initial diagnosis.

Radiation and chemotherapy were used as last ditch efforts and proved ineffective in this review. From this review, any effort in improving survival of these patients must be directed at early diagnosis and aggressive surgical removal of these lesions.

The Author
DONALD F. TEMPLE, M.D., F.A.C.S.
Dr. Temple is Assistant Clinical Professor of Surgery at the University of South Florida, Tampa.

The incidence of neoplasms of the small intestine is estimated to be approximately 3-6% of all gastrointestinal neoplasms.[1] This low rate of malignancy has been attributed to an inherent protective resistance in the small bowel.[2]

Neoplasms of the small intestine are usually difficult to diagnose mainly because of the infrequent incidence and also because of the protean manifestations.

This report deals with adenocarcinoma of the small intestine encountered at Roswell Park Memorial Institute over a 25-year period. These cases have been analyzed to determine the pathologic and biologic behavior of these tumors, therapeutic modalities employed, as well as other factors that affect the prognosis and eventual outcome.

Materials and methods • From 1955-1980, 103 patients with primary small bowel tumors were treated at Roswell Park. Twenty-three patients had histologically documented adenocarcinoma of the small intestine and these patients form the basis for this review.

Treatment • Surgical extirpation was the first line of therapy in all these lesions. For patients with duodenal tumors, 4/9 had local resections, two patients had pancreatic duodenal resections, two others had biopsies and gastrojejunostomies, and the last patient had no surgery but was managed supportively.

Ten/eleven patients with jejunal lesions were treated by local resection of the diseased jejunum and mesentery. One patient initially had a bypass procedure but was later reexplored and underwent primary resection. All three patients with ileal adenocarcinoma underwent surgery. Two patients

had local resections and the third patient had a bypass procedure. Surgical reexploration was done on 12 patients following initial surgery. In patients with duodenal lesions, ¾ patients that initially had local resections were reexplored 7th month, 8th month and 11th month respectively. One patient had a whipple procedure and the other two had bypass procedures.

Seven/ten patients with jejunal lesions underwent reexploration for recurrence. The average length of time from initial surgery to reexploration was 13.7 months. The second surgical procedure was further resection in three patients and a bypass procedure in the remaining patients.

Two patients with ileal adenocarcinoma initially treated with local resection were reexplored at five month and eight month intervals respectively for recurrence. Further surgery involved further excision in one patient and a bypass procedure in the other patient.

Chemotherapy and radiation therapy were the other modalities added to treatment (Table 3). Six/nine patients with duodenal lesions were treated with chemotherapy. In two patients chemotherapy was given in an adjuvant setting. One patient had 5FU and radiation. Following recurrence the patient had a bypass procedure and then postoperatively had Cytoxan, 5FU and MTX.

The second adjuvant treatment was initiated in a patient following a Whipple procedure. A combination of Streptozitocin, Methyl CCNU and Adriamycin was used.

Results • Twenty-three patients, 16 males and 17 females, ranging in age from 40-89 years old were studied.

Adenocarcinoma of the jejunum was the most common lesion (11 patients) followed by nine cases of duodenal lesions and three cases of ileal lesions.

Three/nine patients with duodenal lesions are alive nine and one-half years, three and two years respectively. In the other six patients, the survival time ranged from one month to 27 months with a mean duration of 11.1 months (Table 2).

Table 1. — Summary of Symptoms and Signs.

Symptom/Signs	Type of Lesion Duodenal	Jejunal	Ileal
Weight loss	7/9	8/11	1/3
Abdominal pain	8/9	10/11	2/3
Nausea/Vomiting	6/9	9/11	3/3
Hematest Positive Stool	5/9	5/11	0/3
Anemia	3/9	1/11	0/3
Jaundice	2/9	0/11	0/3
Intestinal Obstruction	0/9	8/11	2/3
Intersucception	0/9	1/11	0/3
Perforation	0/9	0/11	2/3

Table 2. — Summaries of the Survival Time Periods of Various Lesions.

No. of Patients in Group	Site of Lesion	Range of Interval	Mean Survival
6*	Duodenal	6 - 27 mos.	11.1 mos
11	Jejunal	2 - 51 mos	29.2 mos
3	Ileal	5 - 25 mos.	14.3 mos.

Three patients with duodenal lesions still alive at completion of this review.

It is interesting to note that all survivors had extensive resection, namely pancreaticoduodenectomy.

All patients with jejunal adenocarcinomas survived less than five years. The longest survival time was 51 months and the shortest was two months. The mean survival time was 29.2 months.

In three patients with ileal adenocarcinomas, the survival time was five months, 13 months, and 25 months respectively with a mean survival time of 14.3 months.

Discussion • In a period of 25 years, 103 patients were sen at Roswell Park Memorial Institute with primary small bowel tumor. Of these patients 22.3% (23/103) had primary adenocarcinoma of the small bowel.

In a review by Perzin and Bridge adenocarcinoma of the small bowel varied from 27-57% incidence. The most important factor, however, is that, in general, adenocarcinoma of the small bowel is very rare when compared to large bowel malignancies.

The reason for the lower incidence of adenocarcinoma of the small bowel is still one of conjecture. Several theories have been advanced. These include the fluid alkalinity of the small bowel contents and rapid transit-time.[2-5] In this review, attempts were made to find associated etiologic processes. There were no associated cases of regional enteritis or villous adenoma.[6] Radical extirpation is the mainstay in management of small bowel adenocarcinoma particularly for duodenal lesions. Three/nine patients with duodenal lesions treated by radical pancreatics duodenectomy were alive nine and one-half, three years, and two years respectively. Local excision was associated with local recurrence and must be strongly discouraged for duodenal lesions.

Table 3. — Chemotherapy Agents Used To Treat Recurrent Jejunal Adenocarcinoma.

Chemotherapeutic Agent	No. of Cases
Streptozitocin/5-Fluorouracil (5FU)	1
Adriamycin/Streptozitocin/ Methyl CCNU	1
*5-Fluorouracil (5FU)	2
DTIC	1

*Used in combination with radiation therapy

The major setback in the timely treatment of small bowel tumors is the delay in the diagnosis due to the protean manifestations of symptoms. In most cases, when symptoms are fully manifested, the disease is far advanced.

At Roswell Park there was no adjuvant protocol or chemotherapeutic regimen for advanced disease.

Modalities of chemotherapy and radiation were used as a last ditch effort and with no real success.

Improvement in management probably will come with more aggressive attempt at early diagnosis. The use of gastroduodenoscopy should increase the diagnostic yield with duodenal lesions, and aggressive use of gastrointestinal radiography for early symptoms such as anemia (43.4% in this series). Perzin and Bridge also report a high incidence of anemia but unfortunately 22/43 in their series did not have gastrointestinal radiography despite a history suggestive of anemia.

The five year survival of patients with adenocarcinoma is dismal.[7-9] Pagtalunan and others reported a 22% five year survival.[10] The results from our series is even more dismal. With more aggressive diagnostic assessment leading to expeditious treatment, we should be able to improve on these results.

References

1. Braasch, J.W. and Dengo, H.E.: Tumors of the Small Intestine, Surg. Clin. North AM 44:791-196.
2. Calman, K.C.: Why are Small Bowel Tumors Rare? Ao Experimental Model, Gut 1974, 1S, 5S2-5S4
3. Bridge, M.F. and Perzin, K.: Primary Adenocareinoma of the Jejunum and Ileum, Caoeer 36:1876-1887.
4. Lowenfils, A.B.: Why are Small Bowel Tumors So Rare? Laneet 1:24, 1973.
5. Williamson, R.C.H.; Welch, C.E. and Malt, R.A.: Adenocarcinoma and Lymphoma of the Small Intestine, Annals of Surgery, Feb. 1983, Vol. 197, No. 2, pg. 172-178.
6. Steinberg, L.S. and Guieber, W.: Villous Adenomas of the Small Intestine. Surg Vol. 71, No. 3, pp. 423-428, 1972.
7. Brooks, J.A.; Waterhouse, J.A.H., and Powell, D.J.: Malignant Lesions of the Small lotestioe — A Ten Year Survey, Br. J. Surg 55:405-410, 1968.
8. Darling, R.C. and Weleh, C.E.: Tumors of the Small Intestine, N Engl. J. Med. 260:397-408, 1959.
9. Wilson, J.M.; Melvin, D.B.; Gray, G.E., aod Thorhjarnarson, B.: Primary Malignaneies of the Small Bowel, Annals of Surgery, Vol. 1, No. 2, August 1974, pp. 17S-179.
10. Pagtalunan, R.J.G.; May, C.W., and Doekerly, M.D.: Primary Maligoant Tumors of the Small Intestine, Am. J. Surg. 108, 13-18, 1964.

- Dr. Temple, Assistant Clinical Profesor of Surgery, University of South Florida, 829 West Buffalo Ave., Suite 101, Tampa 33603.

Health Care Assistance Corporation
And
C&S National Bank of St. Petersburg

PRESENTS



AFFORDABLE LONG-TERM HEALTH CARE FINANCING FOR YOUR PATIENTS

Ever wonder how you could offer your patients small monthly payments, increase your collections, and decrease or eliminate your present and future accounts receivable?

You can! The answer is the **Health Cap** Credit System. Sound like Utopia? It could be. *Through the use of our state-of-the-art electronic "Pace" Bank Terminal Machines* your patients can be given a monthly credit payment plan while you get your fees entirely *up front.* All of it at once. No waiting. No collection problems, with no financial risk on your part.

You can be part of this exciting business program that has been tailored to meet the specific needs of the health care professionals and their patients.

We Offer You:

- Instant Collection of fees the day services are rendered.
- Automatic Fund Transfer
- Increased Case Acceptance for elective procedures
- Greatly Increased Collections
- No Accounts Receivable
- No Credit Risk To You
- Low Discount Fees on Mastercard, Visa, and Choice transactions (the lowest available in the country)
- Telecredit, Honor, American Express, Diners Club, and Carte Blanche Authorizations

CALL OR WRITE FOR OUR LATEST BROCHURE TODAY

813-885-6584 800-282-5599

Health Care Assistance Corporation
8316 Hanley Road • Tampa, FL 33614

ADD NEW PATIENTS

A Nutrition Medical Centers franchise can help your practice grow. A logical extension of your professional knowledge and facilities, our proven system of nutrition counseling can create a new profit center for your practice. For more information on this exciting opportunity call (404) 872-4900.

NUTRITION MEDICAL CENTERS

1750 Peachtree St. N.W.
Suite 305
Atlanta, Georgia 30309
(404) 872-4900

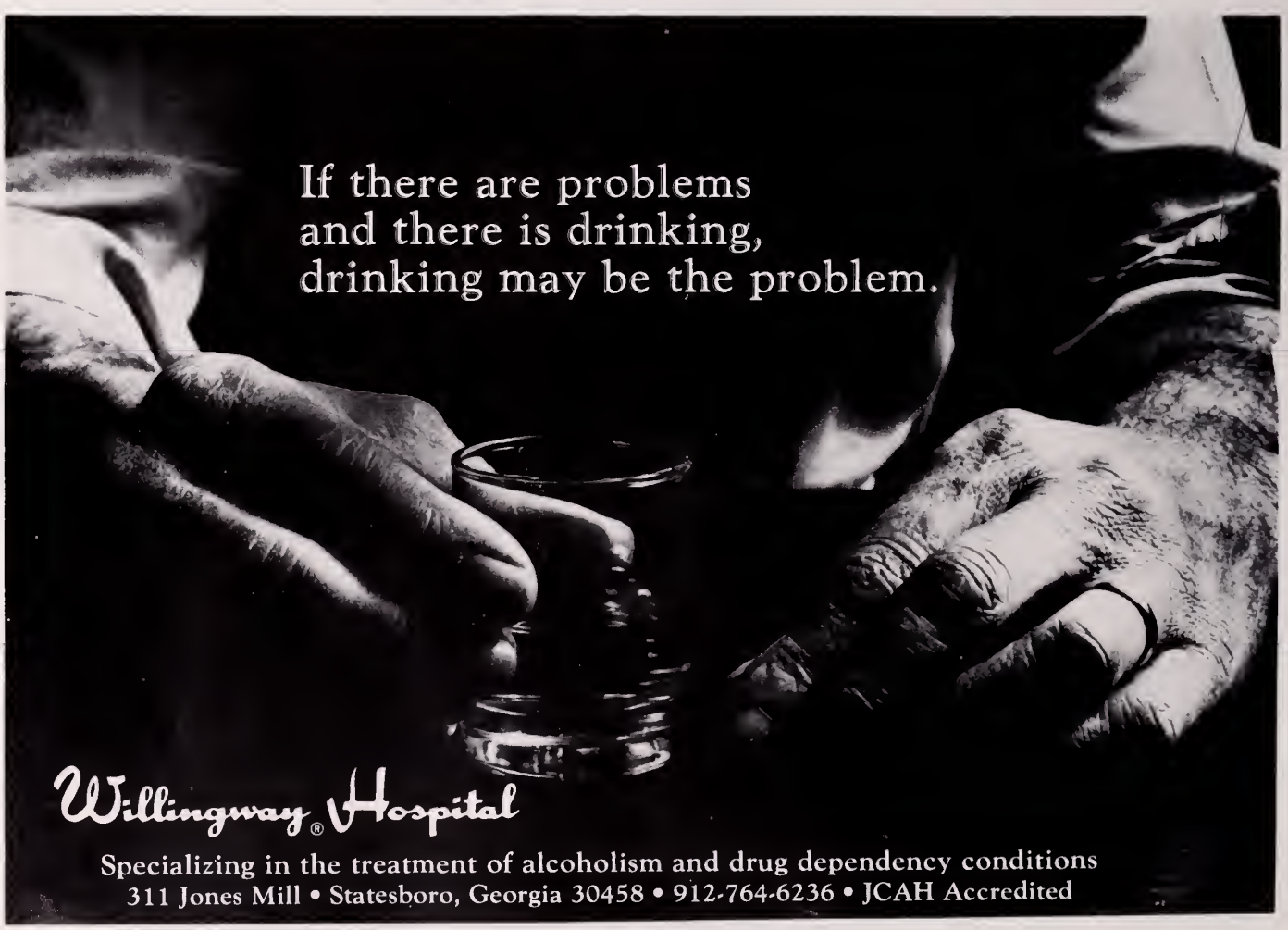
Government Printing Office Bookstore

Jacksonville, Florida

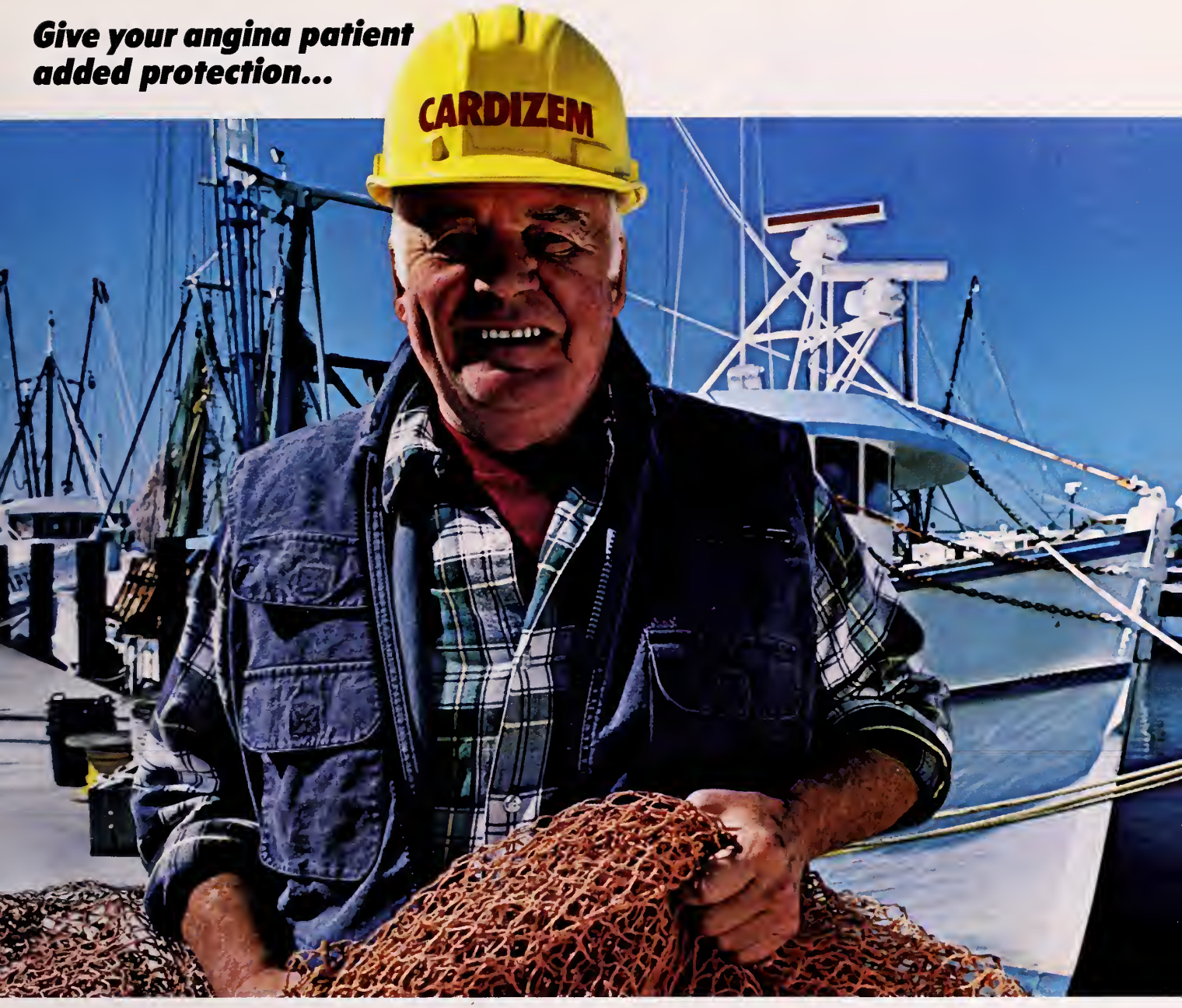
The Government Printing Office Bookstore in Jacksonville, Florida carries in stock the International Classification of Diseases, 9th edition (ICD-9). This three-volume set contains the codes used in filing insurance claims. Price: $29.00 (paper edition) and $40.00 (cloth edition).

The book store also carries in stock four different formats of the HCFA Form 1500, used for filling out Medicare claims. The two-part carbonized snap-out form used most by doctors sells for $13.00 per 100-count package. Pre-payment is required, although there is no tax or no postage charge for 4th class mailings. Make check payable to Superintendent of Documents, or charge orders to MasterCard, Visa or Choice.

Government Printing Office Bookstore
Federal Building, Room 158
400 West Bay Street
Jacksonville, Florida
(904) 791-3801



Give your angina patient added protection...



CARDIZEM®: FEWER SIDE EFFECTS

diltiazem HCl/Marion

- ***The lowest incidence of side effects among the calcium channel blockers[1]***
- ***An exceptionally safe choice for angina patients with coexisting hypertension, diabetes, asthma, or COPD[1-3]***
- ***Proven efficacy when used alone in angina[1, 4-6]***
- ***Compatible with both beta-blockers and nitrates[7]***

Please see brief summary of prescribing information on the next page.



CARDIZEM® 60 mg tid or qid

diltiazem HCl/Marion

FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

BRIEF SUMMARY

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist).

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM (diltiazem hydrochloride) in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence:

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGDT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted.

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGDT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other. Issued 4/1/84

See complete Professional Use Information before prescribing.

0642T5

References: 1. *Physicians' Desk Reference®* ed 39. Dradell, NJ, Medical Economics Company Inc, 1985. 2. Cohn PF, Braunwald E. Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease. A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 3. Schroeder JS: Calcium and beta blockers in ischemic heart disease. When to use which. *Mod Med* 1982; 50(Sept):94-116. 4. Subramanian VB. Comparative evaluation of four calcium antagonists and propranolol with placebo in patients with chronic stable angina. *Cardiovasc Rev Rep* 1984; 5:91-104. 5. Schroeder JS, Feldman RL, Giles TD, et al: Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 1982; 72:227-231. 6. Weiner DA, McCabe CH, Cutler SS, et al. The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. *Clin Cardiol* 1985; 7:648-653. 7. Shapiro W. Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec):150-159.

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137

SPECIAL ARTICLE

Prison health care: problems and alternatives in delivery of health care to the incarcerated — Part I

Jacqueline M. Moore, R.N., M.S.N.

> A prisoner is potentially in worse condition than the slave because the slave is the property of someone whose interest is to keep his property in serviceable condition, whereas the prisoner is owned by nobody, unless it be the State which is ultimately responsible for his imprisonment. Consequently, the conditions of prisons and their prisoners are not a bad indication of the development of any society (at a given time) and its degree of civilization.
>
> Kenneth Ruck in his introduction to 1929 Everyman edition of John Howard's *"The State of the Prisons in England and Wales."*

Status of health care in jails ● In theory a prison health care system differs very little from many other health systems. Primary care services including medical, dental, and psychiatric services must be provided efficiently, effectively, and equitably to the entire population. Access must be assured when needed and referrals, hospitalization, diagnostic evaluation and follow-up care must be integrated into the program.

Generally, prison medical programs fail miserably to adhere to this concept. There is virtually no linkage within the various elements of the program or an awareness that such elements should exist.

Most studies performed in correctional health care cite many deficiencies in the delivery of health services to this population. In a national study on correctional health care conducted by the American Medical Association in 1972 it was revealed that:

One fourth of the nation's 4,037 jails had no medical facilities whatsoever;

In 65.5% of the 1,159 jails analyzed, first aid was the only medical care available;

In 16%, first aid was not even offered;

In 28% of the jails, physicians made no regularly scheduled visits and in 11.4%, physicians were not even available on call.

Despite the methodological limitations of the AMA study associated with the low response rate of the survey (40%), and the reliability considerations associated with not being able to validate the information on the self-report form, the study "indicated that medical manpower, equipment, and facilities did not exist on a formal basis in the majority of the nation's jails and, where it does exist, there was no assurance of its adequacy."[1]

Recent investigators who have done similar surveys have found that many of the problems addressed in the American Medical Association Report still exist in today's jails.[1,2] Obviously, these studies indicate a need for more adequate planning and delivery of health care services to the incarcerated, but this task is not easily accomplished.

Provision of health care in a correctional setting is beset with many problems and too few solutions. Difficulties in staff recruitment, inadequate resources, poor health status of the inmate, overutilization of health services and restraints imposed by security all contribute to an inadequate delivery system. In the sections which follow, these problems are examined along with supportive evidence from a review of existing empirical literature.

The Author
JACQUELINE M. MOORE, R.N., M.S.N.
Ms. Moore is with Prison Health Services, Inc., Wilmington, Delaware.

Inmates enter jail in poor health ● Reflective of their disadvantaged background, prisoners are more likely than the general population to harbor serious, undetected health problems. The majority of illness

and complaints experienced by inmates is clearly related to their previous addictive or criminal lifestyles or associated with the overcrowded conditions of incarceration. Drug and alcohol abuse and psychiatric disorders have been identified as the most common health problems of inmates.[3-5] The high percentage of drug abusers among prisoners leads to an increased frequency of secondary medical conditions such as gastrointestinal disorders, endocarditis, or seizures that are directly related to drug use and its subsequent withdrawal. Other health problems which are predominant in the prison setting include: trauma, lacerations, skin and dental diseases, musculoskeletal disorders, respiratory infections, veneral disease, tuberculosis, hepatitis, hypertension, epilepsy, and recently, AIDS.[6-8]

Minor psychosocial disorders grouped together under the symptoms labeled as anxiety or depression presented the most common complaints seen at sick call. On individual charts, these symptoms are generally manifested in the form of sleep disturbance, nervousness, headaches, dizziness, chest pain, musculoskeletal pains, abdominal pains, and dizzy spells.[4,8,9] While many of these symptoms cause discomfort, few are disabling and most can be treated within the context of primary care.

Suicide is the leading cause of death in jails and yet it is also the most preventable.

Suicide is the leading cause of death in jails and yet it is also the most preventable. Although it is impossible to know how many jail suicides are averted by prevention practices, suicide rates for jail populations throughout the country remain alarmingly high. While estimates of suicides rates for the general public range from ten to 14 per 100,000 population, rates of 108 per 100,000 have been reported in jail populations.[10]

Another high cause of mortality in prisons is related to trauma and violence (approximately 25%). Most prisons are suffering from overcrowded conditions and crowding sometimes explodes with a crushing force such as that experienced by the recent riots this past summer in Tennessee and West Virginia. Causes of trauma are self-mutilation, abuse or assault by other inmates, or trauma inflicted by the correctional officers.

Volume of health services utilized in jails ● Investigators who have studied health care service utilization by inmates report extremely high utilization rates. Young and Carr found that in a medium security prison with an annual admission rate of 3,178 inmates and a daily population of 261, there were 1,122 visits to the medical unit in a six month period.[8] Similarly, Derro reports that of the 491 patients admitted to a 120 bed minimum security prison over a year, 312 or 65.5% sought medical care at least once during their incarceration;[7] and Eichold states that in a 400 bed prison, over a 28 day period, there were 423 sick call visits made by 210 inmates.[11] Over 50% of the population made a sick call visit by day nine and 75% by day 14. When these figures are computed against averages reported in the National Medical Care Survey of 1973 which show that the average male of comparable age uses health care 2.6 times in a year compared to the 7.7 rate of physicians visits per inmate reported by Derro, it is clear that inmates tend to overuse health services relative to other populations, and a large number of visits are frequently made by a small portion of those seeking care.

Eichold showed that prisoners' utilization of health services is related to their perceived health status. Variables relating to health perception, past hospitalizations, prior history of health problems or abusive pattern with drugs or alcohol, history of mental illness, and years of education were examined. As expected, Eichold reported a highly significant statistical difference in inmates who perceived themselves as ill, had prior history of mental or physical health problems and who were taking medications or treatment at the time of their incarceration.

Admitteldy, there are numerous causal factors related to illness. These range from genetic predisposition, personality type, infection transmission, injury and diet to immune level to stress. Studies related to population characteristics have identified an association of each of these variables with health care utilization. For example, Twaddle found that the proportion of inmates appearing at sick call varied with race, age, and marital status.[12] Blacks were more likely to use medical services than whites and sick call usage was inversely related to age (i.e., the youngest group had the highest proportion of sick call). There was an overall pattern in which single or married inmates used sick call more frequently than widowed or divorced inmates. Neurotic offenders made more emotional visits to sick call than did other personality types and psychopathic offenders demonstrated more malingering behavior than did the others.[13]

While illness was certainly a factor in generating a request for sick call, personal motives of the inmate such as malingering, thievery of drugs or medical items, harassment of the medical staff, tranquilization-seeking behavior, attempting to gain special favors, socializing, or use of an outside trip to decoy an escape plot also affected medical utilization patterns.[14]

Sickness real or imagined can be used as a means to escape from work, boring routines or to provide access to the luxury of a hospital. The extent to which a symptom remains "ill defined" versus a "disease" depends greatly on the physician's willingness to pur-

sue diagnostic investigations and an arbitrary criteria for judging sincerity. Patients in family practice are regarded as sick until proven otherwise; the converse is frequently the case in prison health care.

In the correctional system, physician judgment becomes both clouded and compromised by the significant number of requests he receives that are not well delineated; lack of ancillary diagnostic services available; unreliability of the inmate as a historian, and cultural and communication barriers associated with having middle class providers care for predominantly foreign and minority populations. The time and effort necessary for the physician to probe, explain, provide insight, gain acceptance or achieve confidence with the detainee is notably absent and it is not uncommon for the detainees to see the medical service as another instrument of oppression and are alert for ways to "rip it off."

Prison organization and health care utilization • In addition to personality characteristics of the detainees, health care problems seem intrinsically related to the nature of the prison organization. Crowding, noise, and loss of privacy and control are characteristics common to all correctional environments. The association of these variables to hypertension, aggression, increased endocrine arousal, decreased ability to solve complex problems, increased transmission of infectious diseases, and depression are well established in health care literature. Depending upon the inmates' adjustment to correctional routines, great uncertainty regarding their life outcome may exist. Such real or perceived threats to survival can be expected to activate body functions developed to assure survival in an abnormally high hyperactive state.

West in 1972 found that minor ailments were magnified by inmates and that close living conditions intensified the effect of illness experienced by the inmate. Diabetes, asthma, peptic ulcers, and epilepsy have been found to be exacerbated as a result of incarceration. Seemingly then, it appears that prison life is not conducive to one's health and may, in fact, aggrevate many medical conditions.

Organizational rules regarding security issues frequently compound medical utilization problems. Security concerns with drug hoarding and bartering by inmates necessitate that the inmate must return to the medical unit on a daily basis for medication; cardiacs are frequently prohibited from having their nitroglycerin, asthmatics their aspirators, and diabetics access to insulin. The absence of alternative care such as home remedies or nonprescription drugs makes the detainee totally dependent upon the prison medical staff and, consequently, accounts for the fact that prisoners use medical facilities much more frequently than civilians.

Nonmedical control of prison life and its effect on health care • The failure to provide an adequate health care system for the incarcerated becomes even more understandable if one examines the goals of correctional institutions and those of the medical departments. Jails exist for the purpose of security. Health care services with their outside medical trips and inside hospitalizations are not seen as contributing to that goal and are frequently given low priority. Unlike the situation confronting free patients, security functions of prison life determine the nature, timing, and form of medical care available. Every aspect of prison life such as housing, location, diet, hours of rest, time of physical movement, and form of communication is controlled by persons other than the inmate or health staff. As a result, the medical team must organize and reorganize its services around security in order to deliver health care.

As a result, the medical team must organize and reorganize its services around security in order to deliver health care.

Nonmedical control for prison life has three implications in the provision of health service to inmates which are: access to treatment, treatment parameters, and confidentiality of medical information,[15] (Neisser, 1977). Generally, correctional procedures determine when and where an inmate can receive health care and the procedure for obtaining it. Many correctional officers have become cynical and distrusting of inmates and may withhold sick call request for all but the most obviously ill. Beyond that, many correctional staff have been known to utilize the medical department to their advantage by either withholding it as a disciplinary measure or granting it as a special privilege. In either case, it is likely that a number of inmates actually needing medical care are not receiving it.

Second, treatment, when provided, is tightly regulated. Prescription drugs are dispensed one dose at a time. The inmate cannot obtain a heating pad, alter his diet, or check his blood pressure without medical orders and correctional acquiescence. Moreover, sick call, outside medical appointments, and midday medications may be missed if the inmate is scheduled to appear in court or if security is short-staffed.

Third, security conditions also affect the confidentiality of medical information. Routinely, inmates are not told of scheduled ouside medical appointments because of concern for a potential escape. Correctional officers are always present during medical examinations which may inhibit an inmate's willingness to discuss his medical problem and, finally, the warden or internal affairs investigators have access to all medical charts which further violates patient confidentiality issues.

The pervasive overlay of nonmedical controls requires the medical staff to organize their program

and schedule to make optimum use of the limited time and space allotted to them. In short, prison medical staffs must become efficient planners if they are to provide effective medical services. They must organize their programs to ensure that the regimentation of security does not frustrate effective health care delivery. Thus, while the prison has been charged with responsibility for provision of medical care programs, it is essential that the medical staff become the health administrators of them.

The pervasive overlay of nonmedical controls requires the medical staff to organize their program and schedule to make optimum use of the limited time and space allotted to them. In short, prison medical staffs must become efficient planners if they are to provide effective medical services. They must organize their programs to ensure that the regimentation of security does not frustrate effective health care delivery. Thus, while the prison has been charged with responsibility for provision of medical care programs, it is essential that the medical staff become the health administrators of them.

In short, prison medical staffs must become efficient planners if they are to provide effective medical services.

Limited financial resources • Any discussion of the basic features of prison medicine must include a discussion of the all-pervasive factor of inadequate resources. The soaring costs of health care services have affected the middle class as well as the indigent, free as well as those incarcerated. The fact that too little money has been allocated toward prison health care is well documented in both criminal justice and medical literature. Prison adminstrators argue that health providers are expensive, prisoners demand a great volume of services, and prison budgets are notoriously underfunded.[16] Overcrowded conditions and increased rates of incarceration further cripple health care budgets. As of June 30, 1983, there were 177 sentenced prisoners per 100,000 people in the United States. Since 1974 the incarceration rate has increased by 70% and continues to grow at an annual rate of 10-12%.[17] Today the U.S. Bureau of Justice reports that there are over 429,603 people incarcerated in our nation's jails.

Competition for government funds • In most localities inadequate financial support has been a major block in development of adequate and humane health care services for prisoners. Officials of city, county, and state governments claim that their treasuries are caught in a crunch between limited revenue producing capabilities and increasing demands for public services in many forms. Realistically, funding for correctional health care is frequently given a low priority when it must compete with funding for security which is the primary goal of the jail.

Slightly less than 3% of all government spending in 1981 was for the criminal justice system. Of this 3%, 1.5% was allocated for law enforcement and investigations, 0.7% for corrections, and the remaining 0.7% for legal services involving prosecution and public defense.[17]

Health care in correctional facilities is considered to be a free good for inmates since there is no direct link between consumption and payment. The lack of economic barriers and the ready accessibility of the service encourages inmates to overuse health care and further wastes limited resources. The complete lack of economic barriers in terms of both "dollar and time costs" also encourages inmates to seek care for minor complaints.

Free goods provided in the public sector are "free" only to certain individuals; they are most certainly not free from the viewpoint of society. Taxpayers must pay for goods that the government might choose to distribute free to other individuals. Individual taxpayers following their own self-interest will refuse to voluntarily pay for a public good, resulting in a underallocation of resources for health care to detainees. Additionally, political entrepreneurs seeking to win elections have strong incentives to support policies that do not increase taxes to pay for the health needs of this population.

Problems caused by inadequate resources • The lack of adequate resources for correctional health care has made it difficult to attract numbers of qualified medical staff. Frequently the staff are confronted with a difficult population in an unattractive and isolated setting which further compounds the recruitment problems. Generally, in most state and local prison systems, allowable rates of reimbursement to physicians for services rendered to inmates are substantially lower than that for the same type of service if provided under Medicare or Medicaid or in a federally assisted health care program. Consequently, in most instances, physicians who are willing to work in prison settings receive rock-bottom remuneration. In many prisons there is not only a shortage of staff in the numerical sense but the staff may lack sufficient training or qualifications to carry out their responsibilities. It is not uncommon to find prison medical staffs comprised of foreign physicians, paramedics, and other low-salaried health professionals.

In many small jails medical care is not provided on the premises and the sick inmate may have to be escorted to a hospital or physician's office. In these cases, the health care of the inmate is determined by

the correctional officer since the inmate cannot seek medical care on his/her own. If the correctional officer is ignorant or callous, the inmate may be denied access to medical treatment.

Besides the difficulties encountered in staff recruitment, the problem of inadequate financial resources has resulted in lengthy waits of months and even years for nonemergency services and consultant referrals.[18] The General Accounting Office (GAO) concluded in its 1978 study that "to varying degrees, federal, state, and local prisons do not meet minimal standards for providing adequate levels of care, physical examinations, medical records, staffing, facilities, and equipment." From a prisoner's perspective, correctional health services can rightly be called a third class level of care.

Correctional health care budgets • Health care spending in state and federal prisons was approximately $215 million in 1980 which averaged about $756 per prisoner. While this budget more than doubled the national average of $375 per prisoner spent in 1975, it still proved to be insufficient. Mitgang reports that "despite a sudden sizeable infusion of tax dollars over the past five years, the quality of physical and mental health care in America's prisons is only slowly emerging from the dark ages."[19]

Today, following the 1975 court order overhauling all aspects of prison life, Alabama spends $1,029 per prisoner on health services, up 1,459% from ten years ago when it spent $66 per prisoner. States spending the least amount of money for health care are primarily concentrated in the south and west. Among them, Texas ranks last in the nation, spending $213 per prisoner which is 508% more than the $35 spent in 1975. Other low spenders include: Missouri, $213 per prisoner; West Virginia, $275; Wyoming, $283; Arkansas, $336; North Dakota, $362; Louisiana, $380; Georgia, $408; Hawaii, $467, and Iowa, $500.

States which rank among the top ten in terms of health care spending per prisoner have been under federal court order to improve their care. Another significant factor which has inceased health care spending is the realization by legislators of the liabilities involved in the failure to provide an adequate health care delivery system.

Many courts have taken the position that cost should not be a factor in determining what is "adequate" health care for prisoners. The principle that a limited budget will not justify insufficient care has been clearly acknowleded by numerous courts. The position of Judge Blackmum in *Jackson v. Bishop*, 404 F.2d, 571 (C.A. 8, 1968) is representative: "Humane considerations and constitutional requirements," he said, "are not, in this day, to be measured or limited by dollar considerations. . ." (404 F.2d, at 580). Thus, it would appear that where health care is needed, the court would require that it be provided regardless of cost.

It is clear that more funds are needed to provide the sort of health care which the courts have determined is a prisoner's right; however, the question must be raised as to what extent should funds presently allocated to other programs such as welfare, education, and public hospitals be drawn off to provide for this need? Public resources are limited and legislators must make decisions regarding their use. In would seem that a more comprehensive strategy would be to improve the health care delivery systems of prisons and jails to make better use of available health care resources.

References

Available upon request.

Part II of this special article on prison health care will be published in the August issue of *The Journal*.

• Ms. Moore, Prison Health Services, Inc., 1200 Philadelphia Pike, Wilmington, Delaware 19809.

Confessions of a would-be health care entrepreneur

Richard J. Feinstein, M.D.

Sometime in early 1982, a colleague asked me to participate in the development of a prepaid health care system: an HMO. Relatively few HMOs were functioning in South Florida at that time, but AV-Med and the IMC Gold Plus HMO were in business and gaining momentum almost daily. IMC had just been awarded the first Medicare HMO contract in the nation, based largely on HCFA's interest in both HMOs and in IMC in particular.

It was obvious to me that the age of unlimited federal and private funding for health was coming to an end, and it was also obvious that those who started early to develop their own prepaid health plan would most certainly catch the metaphorical golden worm. I agreed to join the fledgling HMO, which we soon called Physicians HMO, and set out to work. Three internists about my age, a middle management hospital financial administrator, and I set about to obtain a state HMO license and get our project off the ground.

There was tremendous physician resentment in Dade County at that time toward all such endeavors, and we feared that general knowledge of our project would provoke outrage and an early destruction of the HMO, and so we agreed to secrecy until such time when most of the plans had been finalized and the project was near completion. We hired a lawyer, who was a friend and counsel for one of the members of our group.

The Author
RICHARD J. FEINSTEIN, M.D.
Dr. Feinstein is Clinical Associate Professor of the Department of Dermatology of the University of Miami School of Medicine, Miami.

We started meeting secretly by ourselves two or three nights each week, and occasionally with our lawyer, at a $100 per hour, to discuss details of what was needed to obtain the license from the state. We each contributed $4000.00 to pay the attorney, and after a while an accountant was hired to begin preparing actuarial and accounting reports. After about nine months, the project began to take shape as the huge state HMO application became more and more completed, encouraging us to forge on.

I estimate that at that point we each had spent about 150 hours reading material and at meetings, and perhaps that expenditure of time and money encouraged us to think about structuring the Physicians HMO as a limited partnership, with the five of us serving as the general partners. We would each make the same cash contribution as the limited partners, but would be given slightly more profits, if and when they were generated, by virtue of our hard work and entrepreneurial activities. We also favored that structure to prevent losing control of our HMO to a majority of the other doctor limited partners.

Our next step was to obtain commitments from a large number of physicians who were needed to participate to fulfill the state's requirement for a license. We needed physicians from all the major medical and surgical specialties, and we began to meet privately with a number who we knew would be influential and pivotal in the success of the project. While some expressed reservations about the entire concept of HMOs, many seemed willing to cooperate both as participating physicians and as limited partners. The administrators of several local hospitals expressed interest in the project and gave tentative commitments for use of their hospital to obtain the license.

While we discussed our plans in private with key physicians, news about the project was leaked to physi-

cians at our main hospital, and we became aware that misinformation and consternation were prevalent among many physicians, some of whom believed themselves to be key doctors, who we had neglected to speak with in private. It was time, we believed, to go public and present our plans to the medical staff of the hospital.

A meeting was announced on Monday for a 6:00 p.m. meeting on Tuesday in the hospital conference center and a brief description of the project was written, photocopied and delivered to 125 medical offices. Wine and cheese were ordered.

A speaker's table was set up near a chalkboard at the front of the conference room. The wine and cheese table was slowly vacated as we signaled the start of the meeting. Two of our group of five sat at the head table, and our lawyer sat nearby. We began when the initiator of the project, an oncologist in his late forties, made some introductory remarks. I was next and related the history of prepaid health systems, their impact on such cities as Minneapolis, L.A., and Milwaukee, and their obvious importance to Florida in the decades to come. The last to speak was our lawyer, who drew two attached circles on the chalkboard; a small upper circle, labeled the general partnership, and a larger though lower circle, labeled the limited partnership. He spent about five minutes describing the proposed financial relationship and sat down. His talk appeared to be spontaneous and ill-conceived and was as destructive to the project by itself as a dozen other mistakes made by the rest of us over a much longer period of time.

The 80 or so physicians in attendance were then given an opportunity to voice their opinion of the HMO, which they had only learned about in the prior 24 hours if that were possible, from the amateurish photocopy description and the incredibly inept performance by two general partners and their attorney. A third general partner had become so intimidated by the early signs of the anger of his colleagues that he declined to sit at the head table and withdrew from making a presentation.

We, the fledgling entrepreneurs, were then subjected to one of the most bitter and obscene demonstrations that I had ever witnessed in my life. For over an hour, physicians with whom we had practiced medicine as colleagues for a decade or longer, took the podium to condemn us as communists in one breath, and as opportunistic capitalists in the next. Not only was the HMO attacked, but we were each personally attacked for conceiving the project and attempting to implement it. Our very livelihoods were placed in jeopardy by foot stomping physicians who threatened to deny us all future referrals, for having dared to exploit them by becoming involved in such a plan. Even physicians who had privately expressed a desire to cooperate, foresook us in the wild animus of the public forum.

Needless to say, that evening initiated the destruction of our HMO. The major hospital which we had been contracting with withdrew its support in fear of retaliation by the majority of its medical staff, who had demonstrated so violently at the conference. Now, some three years later, there are one or two of those angry physicians who I still have not even spoken with, and some close referral patterns were destroyed forever by that experience.

The HMO project cost each of us $4000 and more than a 150 hours of time, but I did learn from that experience. I learned that despite my belief that I am an intelligent and articulate individual, I am not capable of organizing people, especially physicians, into endeavors that may be beneficial but not understood or wanted.

The experience also reaffirmed my belief that most physicians, including myself, are miserly, and that cheapness pervades our lives and prevents us from acting magnanimously and extravagantly, qualities often required of successful entrepreneurs.

That experience has made me more reflective about the many new HMOs and other health care businesses that are flooding into Florida. Many physicians are angry about the entrance of entrepreneurs into the health care field, believing naively I feel, that they themselves should be the owners and managers of these health care corporations. Although I run an efficient solo medical practice, I failed miserably as a novice health care entrepreneur to get that HMO going, and I believe that it is mere folly for many physicians to consider organizing health delivery plans for themselves which would in theory capture patients away from large corporations run by businessmen.

Few physicians make good businessmen, and I sometimes flatter myself into believing that a good physician cannot also be a good entrepreneur.

Few physicians make good businessmen, and I sometimes flatter myself into believing that a good physician cannot also be a good entrepreneur. A recent report in *JAMA* on compulsiveness in physicians,[1] found doubt, guilt, and indecisiveness, the three hallmarks of a compulsive personality, in almost all medical doctors studied. These traits make us doubt ourselves, feel guilty when things do not go well, and perform as many studies as reasonably possible to make sure that we have not missed anything important. Entrepreneurs are more gallant, willing to take risks, and less riddled with guilt and indecision. They have less qualms about hurting other people, which sometimes may include colleagues and friends. If I ever become seriously ill, however, I want my physician to be extremely compulsive and I will not mind at all if he has been an ineffective entrepreneur.

If a physician cannot initiate and control a competitive health care project, why doesn't a group of physicians organize and hire professional management? While many physicians are now doing just this, traditionally doctors have had difficulty agreeing on almost everything, and have been generally unwilling to make the major cash outlays needed to finance important projects.

Whether we like it or not, many of us will eventually become employed by health care corporations or government agencies because we lack the skills necessary to compete on our own as entrepreneurs. As long as we receive a good wage and professional freedom, perhaps we should concern ourselves only with providing high quality health care to our patients.

Reference

1. Gabbard, G.: The Role of Compulsiveness in the Normal Physician, JAMA 1985, 254:2926-2929.

● Dr. Feinstein, 3661 S. Miami Ave., Suite 1002, Miami 33133.



To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
with acetaminophen 500 mg

Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur, they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.
Revised, April 1982

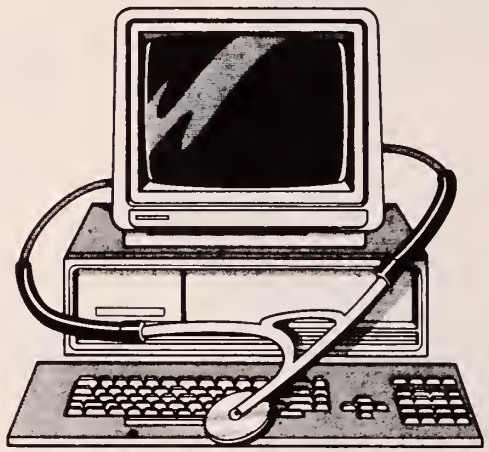
knoll® **KNOLL PHARMACEUTICAL COMPANY**
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

5725
February, 1985

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

Thirteenth Annual Review Course for
Certification in Internal Medicine

"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"

August 17-30, 1986
Key Biscayne Hotel and Villas, Key Biscayne
Director: J. Maxwell McKenzie, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for certification in Internal Medicine. It will provide an intensive and comprehensive survey of those aspects of Internal Medicine which should be familiar to internists qualified for certification and recertification. Printed materials with references and self-assessment questionnaires will be provided to all registrants. This course will end ten days prior to the certification examination of the American Board of Internal Medicine.

A faculty especially selected for its expertise in review courses will present the following topics:

Week I	Week II
Cardiology	Infectious Diseases-Immunololgy
Pulmonary	Nuclear Medicine-Oncology-Genetics
Toxicology-Hypertension-Hepatology	Endocrinology
Renal-Acid Base	Gastroenterology
Rheumatology	Ophthalmology-Critical Care-Dermatology Laboratory
Hematology	Radiology-Neurology-Psychiatry

Highlights

- State of the Art Lectures
- Patient Managment Problems
- Pictorial Quizzes
- Syllabuses
- Meet the Faculty Sessions
- 88 credit hours in Category I
- Self-Assessment Questionnaire Sessions
- Videotape Symposiums
- Audio-Visual Aids

Registration: Entire Course (August 17-30) $750 (before 5/31)
$800 (after 5/31)
Week I (August 17-23) $550
Week II (August 25-30) $550

Includes tuition, printed materials, use of audiovisual aids, library loan of T.V., tapes, cassette tapes and set of slides.

For registration and information write to:
J. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101 Telephone: (305)547-6063



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Physicians' Confidential Assistance

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

Tax deferred plus. . .

There is a serious problem facing many physicians due to the high cost of liability and malpractice insurance. Following is an excellent idea on how to alleviate the gravity of this problem:

First of all, because of the high cost, most doctors are under-protected.

Secondly, all personal and pension assets are legally suceptible to seizure by creditors.

Lastly, The only assets that are exempt from legal process are annuity contracts and life insurance (Florida State Statutes Ch. 22, p. 1310).

> **222:14 Exemption of cash surrender value of life insurance policies and annuity contracts from legal process.** — The cash surrender values of life insurance policies issued upon the lives of citizens or residents of the state and the proceeds of annuity contracts issued to citizens or residents of the state, upon whatever form, shall not in any case be liable to attachment, garnishment or legal process in favor of any creditor of the person whose life is so insured or of any creditor of the person who is the beneficiary of such annuity contract, unless the insurance policy or annuity contract was effected for the benefit of such creditor.

The key solution to this question is in the annuities. Fixed annuities, government bond annuities, variable annuities and real estate annuities are all available.

For further information contact:

Kathleen Ebbers
Account Executive
Prudential Bache Securities
1-800-252-6006

Health Maintenance Organizations: 1986 Update

The growth in the number, in enrollment and in scholarly studies concerning the activities of Health Maintenance Organizations (HMOs) has intensified during the past twelve months. As of June 1, 1986 there were over 600 HMOs nationwide; Florida has 33 of these. Nearly 24 million people are now enrolled in HMOs.

Some physicians would like to deny the importance of HMOs and other forms of alternate health delivery systems and hope that they all will deliquesce and disappear. In contrast, a few vaporous HMO supporters in medicine, government, and the health industries psychedelically project that 70% of the population will have enrolled in HMOs by the year 2000. In the absence of government fiat neither of these options appears likely. A more realistic estimate is that 25%-35% of the American citizenry will receive their care from HMOs within 15 years.

The individual private practitioner is not the only type of health care provider who is suffering adaptive stress as the burgeoning behemoth swallows a larger share of the patient population; the HMO industry itself is developing bellyaches from some of the distasteful changes being imposed upon it such as greater competition from other HMOs and PPOs, more government intervention, changes in financing, and increased risks from the patients enrolled. It is appropriate to examine some of the recently developing issues about and within the HMO industry.

HMO growth and development has been driven by two forces: (1) favorable government attitudes and financing; and (2) the health care cost savings HMOs have been able to give to consumers.

Factions within the Reagan administration want to provide health care for the elderly and disabled by a capitation system that is administered through HMOs.[1] HMOs are widely accepted as being capable of providing health care for less money than can comprehensive insurance coverage obtained in the private, fee-for-service sector of American medicine. The Rand study[2] demonstrated that prepaid group practice in an established HMO (Group Health Cooperative of Puget Sound) provided care for its enrollees at a cost that was 25% less than the cost accrued by patients who received care in fee-for-service practices (and who did not have to pay any coinsurance). These savings were derived from the ability of the HMO doctors to reduce hospitalizations by 40%.

Experience in the Federal Employees Health Benefits Program also indicates that most HMO plans cost the employee less than does traditional health insurance. For instance, the 1985 high option, Blue Cross-Blue Shield plan annual premium was $2,710 for a family of three people. In contrast, the most popular HMO plan (Kaiser in northern California) cost the same family $1,100 per year. Obviously there are differences in the benefits offered by these two plans. If one compares the Kaiser plan with the standard Blue Cross/Blue Shield contract the differences are not so exaggerated — $1,430 for the Blue Cross vs. $1,100 for the Kaiser. A comparison of costs among many HMOs and traditional health insurance plans confirm that HMOs usually provide the consumer with a cost saving between $200 to $500 per year.

There are several reasons that HMOs offer health care at a lower cost. They have always enjoyed a lower rate of hospitalization (they have not been able to reduce costs in the outpatient setting however). HMOs utilize fewer doctors than the non-HMO medical sector. HMOs function with 50% fewer internists and family practitioners and 35% fewer

pediatricians per 100,000 enrollees than does the rest of American medicine. HMOs severely constrain the amount of indigent care they provide. Since the medically indigent now comprise 30% of the population the cost of their care must be transferred to the non-HMO sector. HMOs also prescreen their applicants very carefully to minimize insuring high risk patients such as those with chronic diseases, with histories of increased hospital utilization, and patients who are disabled. Furthermore healthier patients tend to self select HMOs more commonly than do patients with chronic or more serious diseases.[3]

HMO costs will rise because of the proliferation of other HMOs and PPOs which will compete for the health care dollar.

Until recently HMOs have also restricted their enrollment of the Medicare eligible, a group that utilizes twice as much health care per capita than the remainder of the population and a group whose health care costs are more unpredictable. For instance some Medicare patients may consume $30,000-$40,000 of health care resources in a single year. By avoiding these people until very recently HMOs have been able to pass the economic burden of their care to the private sector of medicine.

These cost saving advantages enjoyed by HMOs will fade during the next several years. One reason is that hospitalization rates for the non-HMO sector has and will continue to decline. Secondly, insurance companies are making policy holders responsible for a greater percentage of the total cost of their care, thus reducing the amount of optional care consumed and the cost of their policies to consumers.

HMO costs will rise becausee of the proliferation of other HMOs and PPOs which will compete for the health care dollar. As competition increases HMOs must spend more money on marketing to sustain their patient base. Some now spend 30% of their income on marketing programs.

Some publicly owned HMOs have been able to attract patients by offering very low premiums for a total health care package. These corporations have been willing to sustain losses for three to five years in order to sign up more members. The market value of an HMO is determined by the size of its patient list and not by the health of its balance sheet. Recently investors have become more suspicious of this means of evaluating the worth of HMOs and thus the stock prices of many of them has deteriorated. Capital for new, publicly financed HMOs has sharply declined. Thus new HMOs are not going to continue to compete on cost by living off the capital of the investors.[4]

HMOs will be challenged by increased risks. These risks will come from at least two sources. As the competition increases among alternative health delivery systems HMOs will have to accept less healthy patients to sustain their enrollment. As the federal government alters the methods in which it pays for health care HMOs will become more involved with the Medicare and perhaps, the indigent, populations.

For the past three years some HMOs have been accepting Medicare patients under a variety of contracts. The federal government desires that most Medicare beneficiaries be enrolled in programs in which the HMO assumes the risk of care for its enrollees. Under most risk contracts the government pays the HMO a capitation fee per month. The amount of the capitation allotment is 95% of the average adjusted per capita cost (AAPCC) of health care services in the geographic region in which the HMO operates. The difficulties with these contracts are several. First, the AAPCC varies significantly from over $320 in Miami to less than $170 in some areas of Ohio. This variance has led to the demise of at least one HMO in the Cleveland region. Secondly, HMOs are not allowed to prescreen and exclude high risk Medicare patients and there is no adjustment in the capitation schedule for the random enrollment of excessive numbers of high risk patients. Thirdly, the percentage of the AAPCC paid will be reduced to 93% in 1987. Since profitable HMOs average 5% profit margins, such a reduction threatens to decrease their net income by about 40% unless they can successfully reduce their costs. Some HMOs will statistically suffer from random, adverse patient selection and will lose money; the health care landscape will then become strewn with the carcasses of defunct HMOs.

Non-HMO physicians continually question the quality of care that is offered in HMOs. The issue of quality has been poorly assessed by questionaires in the style of Gallup polls and a true evaluation is most difficult to determine. A report from the Rand study was published in *Lancet*[5] in May. It measured quality with rather soft parameters such as patient assessment of their own health status, serum cholesterol levels, blood pressure readings, weight gain, etc.

This study concluded that quality of care in one HMO was as good as quality of care in the private sector. When the data were stratified for socioeconomic class it was found that patients in the lowest socioeconomic class who had poor health on admission to the study experienced worse health outcomes than did the same group who received their care in the private, fee-for-service sector. Patients in the high income group with poor health at admission to the study did better in the HMO than in the fee-for-service model. Reasons for these discrepancies are unknown. This study is the only prospective comparison of HMO and non-HMO medicine. It cost over $100 million and probably will not be repeated in the

future. It compared care in only a single HMO — Group Health Cooperative of Puget Sound — which is a well established, mature HMO whose costs to certain beneficiaries, such as the federal employees, actually exceed the cost of the standard Blue Cross/ Blue Shield contract for federal employees. Thus it is not typical of many of the HMOs that have appeared during the frantic era of HMO proliferation of the past three years. We still have no way of accurately comparing quality of care or health outcomes between HMO and traditional, private, fee-for-service medicine.

Quality of care in HMOs remains an issue. The television program, "60 Minutes," even questioned the quality of HMO medicine in the Minneapolis-St. Paul area, a region in which 40% of the population belongs to an HMO. "60 Minutes" alleged that HMO patients received reduced quantity of health care services as compared to fee-for-service patients. Even if one assumes that their reporting is accurate (and that may not be a legitimate assumption), equating quality of care with quantity of care is a logical fallacy.

Some HMOs have demonstrated grotesquely flawed conduct. Perhaps the most flagrant accusations of quality deficiencies have been aimed at International Medical Centers (IMC) in southern Florida.

International Medical Centers is the state's largest HMO and has over 200 thousand patients. Unlike all other HMOs, over 70% of its members are Medicare beneficiaries. Federal law dictates that HMOs restrict the percentage of Medicare enrollees to 50% or less of its insured population. However IMC escaped this restriction by obtaining a waiver granted to it by Mr. C. McClain Haddow, a former Medicare official. After Mr. Haddow's departure from government he received a consultation position with IMC. Mr. Haddow is currently under investigation for fraud about other government related matters.

Complaints about IMC have been expressed to the Florida Insurance Commissioner's Office and to the U.S. Congress' House Selection Committee on Aging. The complaints are multiple. IMC has been accused of not paying some of its clients' hospital and doctors bills, of delaying processing of Medicare patients' requests to disenroll (thus allowing IMC to continue to collecting the capitation fee and preventing the patient from having medical services reimbursed for services obtained outside IMC), and of bringing unreasonable pressure upon physicians to discharge patients.

Additionally IMC has had serious financial difficulties that threaten its capacity to provide ongoing care to its subscribers. Current assets at the end of the March quarter were $26.6 million but current liabilities were $48 million. Doctors, hospitals and other suppliers of goods and services are owed $50.8 million. This number is nearly twice its current assets.

IMC has granted $13.8 million in advances and loans to the corporation president, his father, and other principals. The Florida Insurance Office mandated in April that these loans be repaid in installments beginning in May. As of June, the loans were being repaid on schedule.

William Roper, M.D., chief of the Health Care Financing Administration (HCFA), sent IMC a letter on May 30th which effectively withdrew IMC's Medicare compliance assessment (the first step in disqualifying it as a Medicare provider). Dr. Roper stated that "IMC does not have the personnel and systems sufficient for IMC to organize, plan, control and evaluate the health services aspects of the HMO." The Roper letter cited several deficiencies such as the lack of coordination between physicians treating patients in the hospital and those treating the patients after discharge, absence of an effective quality assurance program, lack of adequate data systems, and lack of control over its providers.

The IMC allegations resonate with reminders of the fraudulent abuses that appeared during the 1970s when California sought to enroll its Medi-Cal beneficiaries in prepaid health plans. If the IMC abuses are validated then the enormous opportunity for abuse within a capitation system will again have been demonstrated. Perhaps this demonstration will subdue the ardor of some administration officials for capitation or some type of voucher system for funding Medicare.

The adverse IMC experience has encouraged the federal government to draft new regulations to permit HCFA greater control over HMO Medicare contracts. One new change in the Medicare-HMO law would permit patients to buy insurance for optional medical care outside the HMO. If this law is not repealed then it would permit patients to receive routine care from private, non-HMO doctors and receive their higher intensive treatment from the HMO. This would effectively eliminate the monopoly that HMOs currently enjoy in the provision of all care for the Medicare enrollee and subject the HMO to the risks now assumed by the fee-for-service sector. Many HMO officials admit that this law will prohibit the survival of many HMOs.

At most physician's meetings one can tune into the cacophony of doom and forebodings about the destruction of traditional American medicine by HMOs and other alternative health care delivery systems. Hospital chains, insurance companies, etc. are viewed as financially limitless instruments of pandemonium who want to and will capture American medicine and enslave physicians by transmuting them into corporate employees. Some recent history reveals that these financial giants suffer their own failures in the current milieu of uncertainty and change.

National Medical Enterprises (NME) is a very large hospital management corporation that

discovered that the blending of its hospital interests with HMO ownership to be quite noisome. NME bought and established HMOs within its system. However the physicians on the NME hospital staffs complained bitterly about the fee and utilization controls imposed by the HMOs. Their complaints to the hospital administrators threatened to reduce bed occupancy of the NME hospitals. The hospital adminitrators wanted to keep the doctors happy and the beds filled, while the HMO administrators wanted to eliminate as much hospitalization as possible. Hierarchical disruption resulted and NME has eliminated the major share of its HMO activity in those locales in which it has hospitals.

Humana Corporation has attempted to sell its PPO, Humana Care Plus, with discounts and premium underpricing. It expected that 70% of Humana Care Plus enrollees would use Humana hospitals. However, just a little over 50% of the enrollees use Humana hospitals. Humana Care Plus lost $20 million in the May quarter.

The influx of insurance company or publicly owned national HMOs into a geographical area is not always successful despite their financial strength, experience and marketing. Physicians in central Ohio have structured their own IPA type of HMO and have successfully coerced national HMO chains to leave their market area.

One of the largest national HMO chains, US Healthcare, recently moved into the New York City area but it is having difficulty signing up physicians to service its enrollees. At the end of May it had enlisted only three physicians in the Bronx, only 14 in Westchester County and only 168 citywide. Physicians were apparently unimpressed with the offerings of US Healthcare.

In summary the HMO movement is surging but it has recruited just 10% of the population despite cut rates and incredible government, insurance company, and Wall Street support. It will continue to grow but HMOs are experiencing threatening problems in their bailiwicks just as the private, fee-for-service doctor is experiencing in his. Some physicians enjoy the structured environment of HMOs. To those who prefer the individuality of single or small group practices the evidence suggests that it is not yet time to surrender your identity, ideals, and independence to the corporate sector.

Jacques R. Caldwell, M.D.
Daytona Beach

YOUR NEW LOW DAILY RATES AT AVIS START AT $33.00



Avis features GM cars. Buick Century.

Your association membership means new, uniform low flat rates at Avis. And there's no charge for mileage. Choose from subcompact through full size 4-door car groups:

DAILY RATE	
SUBCOMPACT (Chevrolet Chevette or similar)	**$33.00**
FULL SIZE 2-DOOR (Buick Century or similar)	**$39.00**

These uniform low flat rates make it easy to know your rate before you go. To reserve a car, call Avis toll free: ***1-800-331-1212***

Be sure to mention your Avis Worldwide Discount number: **A/A616900.**

AVIS® ***WE TRY HARDER.®***

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. Flat rates are nondiscountable and are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. An additional charge per day will apply in certain locations including Newark Airport, NJ; LaGuardia Airport, NY; Kennedy Airport, NY; and all Manhattan locations. Check with Avis for the amount. Rates, discounts and additional charges subject to change without notice. Cars must be returned to rental location or higher daily rate and a one-way service fee will apply. Cars and particular car groups subject to availability. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

© 1985 Avis Rent A Car System, Inc., Avis®

THE APPROPRIATE GIFT FOR
AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr.
Mr.
Ms. _____ Status: _____

Street _____

City & State _____

Dr. _____

Street _____

City & State _____

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

FLORIDA MEDICAL
DEPARTMENTS
☐ NOTES & NEWS, 547
☐ ENCORES!, 548

NOTES & NEWS

ACEP begins series on reducing malpractice risk

In a continuing effort to provide updated information about emergency medicine malpractice, the American College of Emergency Physicians (ACEP) has initiated a quarterly publication aimed at helping physicians reduce their malpractice risk.

Foresight, a four-page series prepared under the guidance of ACEP's Insurance Committee, identifies areas of high risk for emergency physicians. It offers physicians practical suggestions on reviewing and modifying their practice to reduce the risk of malpractice in those areas.

Foresight writers use case studies to examine the problems and solutions involved in specific illnesses and injuries. The first issue, appearing in April, provided readers with practical tips for reducing risks when treating two categories of patients — those with chest pain and those with potential meningitis. Subsequent issues will cover other major problem areas. The next issue will be offered in July.

ACEP is a medical specialty society with more than 11,300 members in the United States, Canada and Puerto Rico. Its goals include improving the quality of emergency medical care both by providing continuing education for emergency physicians and through educating the public about the specialty of emergency medicine.

Members of ACEP receive a free copy of each *Foresight* issue. Copies are available for $3.50 each from ACEP Distribution Center, P.O. Box 619911, Dallas, Texas 75261-9911, 214/550-0911.

Physicians needed by Department of Corrections

The Florida Department of Corrections frequently has openings for physicians at one of the 30 institutions throughout the state. These predominantly are in the primary care area but may include psychiatry, internal medicine and gynecology. Interested physicians who have completed one year of post graduate training in a primary care specialty or two or more years of training in other specialties should contact Earle Makant, M.D., c/o Assistant Secretary for Health Services, 1311 Winewood Boulevard, Tallahassee, Florida 32301, (904) 488-2036.

Incidence of cesarean sections higher in Florida than in the nation

The Hospital Cost Containment Board (HCCB) recently sent to the FMA data pertaining to cesarean sections in Florida and the nation for 1984. Total cesarean deliveries amounted to 24.8% of all Florida deliveries in 1984. For the same year nationwide, the rate was 21.2% cesarean deliveries. Nationally this represents an increase in cesarean sections by 28.5% during the last five years. Florida's rate of increase has been significantly higher during the last five years. The Florida Obstetric and Gynecologic Society attributes the higher incidence of cesarean sections in Florida primarily to the professional liability situation in this state. Electronic fetal monitoring tapes must be preserved and are subject to legal review. Hence, any abnormality will usually result in a cesarean section.

Schedule of 112th Annual Meeting Scientific Program

Wednesday, September 17

1:30-4:30 p.m. Section on Chemical Dependency

Thursday, September 18

1:00-5:00 p.m. Section on Diabetes
1:00-5:00 p.m. Section on Internal Medicine
1:30-4:00 p.m. Seminar on the Aging Patient
1:30-4:30 p.m. Section on Chest Medicine
2:00-5:00 p.m. Section on Prevention

Friday, September 19

1:15-4:15 p.m. Section on Clinical Oncology
2:00-5:00 p.m. Section on Colon and Rectal Surgery
2:00-5:00 p.m. Section on Endocrinology
2:00-5:00 p.m. Section on Family Medicine
2:00-5:00 p.m. Section on Orthopedics
2:00-5:00 p.m. Section on Pediatric Cardiology
2:00-5:00 p.m. Section on Psychiatry
2:00-5:00 p.m. Section on Radiology

Saturday, September 20

7:30 a.m.-12:00 noon	Section on Allergy and Immunology
7:30 a.m.-12:00 noon	Section on Obstetrics and Gynecology
7:30 a.m.-12:00 noon	Section on Pediatrics
7:30 a.m.-12:00 noon	Section on Pediatric Surgery
7:30 a.m.-12:00 noon	Section on Physical Medicine and Rehabilitation
7:30 a.m.-12:00 noon	Section on Plastic and Reconstructive Surgery
7:30 a.m.-12:00 noon	Section on Clinical Oncology
7:30 a.m.-12:00 noon	Section on Rheumatology
8:00 a.m.-12:00 noon	Section on Orthopedics
9:00 a.m.-12:00 noon	Section on Ophthalmology and Otolaryngology
9:00 a.m.-12:00 noon	Section on Psychiatry
10:00 a.m.-12:00 noon	Socio-Economic Program

ENCORES!

Selling surgery

Advertising in medicine has become a reality. Although some medical observers may consider increased advertising an encouraging sign of competition, the marketing of health care cannot legitimately be equated with the marketing of other services. Historically, the relation between advertising and the protection of consumers has been in part an adversarial one. Legal constraints designed to prevent deception have been needed to protect the public for most of this century. Protection may be even more necessary now that consumers are selecting health care on the basis of information supplied by the advertising industry. There is little doubt that sophisticated advertising campaigns can effectively increase revenue for surgical specialists, particularly ophthalmologists and plastic surgeons.[1] Advertising may be beneficial to the individual advertiser. But what is its influence on the health of consumers and on the practice of medicine? There is reason to believe that the overall effect of advertising by ophthalmologists may be detrimental not only to the public but also to the specialty itself.

Ophthalmology encompasses both medical and surgical practice. It is the disparity in monetary rewards between these two areas that can be exploited by the successful businessman. Advertisements in the field of ophthalmology are almost exclusively designed to promote surgery. Billboards, radio and newspaper advertisements, and massive door-to-door solicitation using leaflets, as is carried out in Tampa, can seriously mislead the public about the risks of and indications for eye surgery. The following examples are offered to support these contentions.

Cataract surgery is performed to improve the quality of life. The indications for surgery in the vast majority of patients are not absolute and vary depending on the visual needs and life style of the individual. Although cataract surgery is one of the most successful forms of surgery, it is not without risk. A reasonable estimate of the chance of a surgical complication is between 3% and 5%.[2] Cataracts and cataract surgery, however, are portrayed quite differently in newspaper advertisements. Such advertisements may warn that cataracts can "hurt you" and can "endanger" your life because they may lead to an automobile accident. Visual loss from cataracts is depicted as being so subtle that it may go unnoticed. It is implied that surgery is quick, simple, and without risk, and advertisements may include a solemn reminder that sight is precious. This type of solicitation is persuasive, but its effectiveness is based on fear and ignorance among consumers. The association of cataracts with bodily injury and the implication that clinically important cataracts can occur without any perceived visual impairment are cruel and unjustified. It is also unfair for advertisers not to inform consumers that there are alternatives to surgery.

Another commonly advertised service in our community is radial keratotomy, a surgical procedure used to reduce myopia and eliminate the need for corrective lenses. Although the procedure itself has created considerable controversy because it involves making multiple, deep corneal incisions in an anatomically normal eye, it has nevertheless become a popular procedure throughout the country. Nearly one-fourth of the ophthalmologists listed in our local telephone directory advertise radial keratotomy. Most simply state that they perform the procedure, but a few indicate that it is safe and effective. This claim is misleading, since it may be interpreted as promising absolute safety and effectiveness. Both the short-term and the long-term effects of radial keratotomy are incompletely understood. Studies indicate that 10% of those who undergo the procedure are dissatisfied with the results of the surgery and that up to a third of patients complain of fluctuating vision one year after radial keratotomy.[3] Since serious complications can result from radial keratotomy, it should not be considered absolutely safe.[4]

In addition to making misleading or false claims, advertisements can also propagate misinformation through their organization or design. One of the most common misconceptions about cataract surgery, for example, is that cataracts are removed by a laser. Patients are often disappointed to find out that lasers are not used for this purpose. This reaction is understandable, since the public considers lasers an

ultimate achievement of space-age technology. A laser also replaces the scalpel, a symbol that many people fear. Any surgeon who could perform cataract surgery by laser would certainly have a competitive edge over his or her colleagues. Although some advertisements blatantly imply that cataracts are removed with lasers,[5] others merely suggest it by using subtle techniques of design. Advertisements that list surgical procedures often place the word "laser" close to statements about cataract surgery. It is therefore easy to understand why someone unfamiliar with cataract surgery could be confused.

Advertising surgery "for free" is perhaps the most popular and bogus type of solicitation. Advertisements often make unqualified claims that surgery is "free" to the patient and rarely discuss circumstances in which 100% Medicare reimbursement would not apply.

Although surgeons may claim to operate for free, advertising is not an inexpensive investment. A four-inch-by-four-column advertisment four times each week for a month in our city's major newspaper costs more than $85,000. As advertising increases overhead, the overall cost of medical care must also increase.

Are physicians who spend large sums of money in an attempt to sell surgery able to judge objectively who needs surgery? It is becoming apparent that the indications for some types of surgery vary considerably among comparably trained physicians.[6] Could the increased financial burden of advertising compel surgeons to perform more surgery?

The Ethics Committee of the American Academy of Ophthalmology has published examples of misleading and deceptive advertisements along with an analysis of the ethical issues involved.[7] The academy, which has responded to the demands of its membership by taking an active role in dealing with the problems created by advertising, has been careful in drafting an ehtical code that should not be construed as an attempt to restrict trade, according to the guidelines of the Federal Trade Commission.[8]

The ill effects of advertising, however, are not solely the result of deception. Admittedly, many advertisments promoting cataract surgery, radial keratotomy, and eyelid tattooing are not overtly misleading. But while advertisements for surgery flourish, there is a comparative lack of educational campaigns to increase public awareness about important blinding diseases such as glaucoma, diabetes, and age-related macular degeneration. This descrepancy tends to trivialize the specialty and creates an unflattering image of the ophthalmologist. Surgical entrepreneurism can undermine the credibility of ophthalmology by eroding public confidence and may adversely effect the morale of the profession.[9,10]

When advertising informs people of services they might not otherwise have known about, it serves an important function. It is difficult, however, to reconcile an alternative purpose of advertising — to convince people to want something that they do not necessarily need — with the goals of medicine — to reduce suffering and cure disease. The potential benefits of competition among physicians must be carefully measured against the negative effects of the actions of physicians who solicit surgery using advertising tactics that are persuasive rather than educational and who exploit the public's fear and misconceptions about eye disease.

References

1. Caldwell, J.R.: Marketing of Medical Services, J.F.M.A., 1986, 73:47-50.
2. Morgan, L.W. and Schwab, I.R.: Informed Consent in Senile Cataract Extraction, Arch. Ophthalmol., 1986, 104:42-5.
3. Bourque, L.B.; Cosand, B.B., and Drews, C., et al: Reported Satisfaction, Fluctuation of Vision, and Glare Among Patients One Year After Surgery in the Prospective Evaluation of Radial Keratotomy (PERK) study, Arch. Ophthalmol. 1986, 104:356-63.
4. O'Day, D.M.; Feman, S.S., and Elliott, J.H.: Visual Impairment Following Radial Keratotomy: A Cluster of Cases, Ophthalmology (Rochester) 1986, 93:319-26.
5. Academy Advisory Opinion of the Code of Ethics, Ophthalmology (Rochester) 1985, 92:1788-9.
6. Wennberg, J. and Gittelsohn, A.: Variations in Medical Care Among Small Areas, Sci. Am. 1982, 264(4):120-34.
7. Academy Advisory Opinion of the Code of Ethics, Ophthalmology (Rochester) 1986, 93:273-5.
8. Bettman, J.W. Sr.; McCannel, M.A., and Smith H.E., et al: Ethics in Ophthalmology: A Symposium, Ophthalmology (Rochester) 1984, 91:889-900.
9. Weinstein, G.W.: The Buccaneer Eye Surgeon, Ophthalmic. Surg. 1980, 11:831.
10. Idem: The Buccaneer Eye Surgeon, Part II, Ophthalmic. Surg. 1981, 12:171.

Curtis E. Margo, M.D.
Department of Ophthalmology
University of South Florida
College of Medicine

Reprinted with permission from *The New England Journal of Medicine*, June 12, 1986, Vol. 314, No. 24, pgs. 1575-1576.

A Florida physician's testimony to the U.S. Senate on the malpractice problem

Testimony given by Gaston J. Acosta-Rua, M.D., F.A.C.S, Jacksonville, before the U.S. Senate's Labor and Human Resources Committee, submitted to *The Journal* by Emmet Ferguson Jr., M.D., Jacksonville.

Labor and Human Resources Committee
United States Senate

Dear Sirs:

My name is Gaston J. Acosta-Rua. I am a physician specializing in neurosurgery. I have been in private practice in Jacksonville, Florida, since 1972. I am a member of the Lyerly Neurosurgical Group of which I am presently the senior partner. The Lyerly Neurosurgical Group is the oldest group of neurosurgeons in the Southeastern United States and was founded by the oldest living neurosurgeon in the

country. The reputation of our group is well-known not only in the state of Florida but in many other states as well as abroad.

I am a Cuban-American, a graduate of the University of Madrid, Spain Medical School, and I have trained at Case-Western Reserve University in Ohio and as a neurosurgeon at the University of Iowa and the University Hospital in Zurich, Switzerland.

I am a Board-certified neurosurgeon, a Fellow of the American College of Surgeons, the President-Elect of the Florida Neurosurgical Society, and the Vice President of my county medical society. I am also an active member of many civic societies in my community such as the Chamber of Commerce and the Meninak Club.

I have had the honor of being invited to testify on this Committee in regard to the professional liability crisis in the state of Florida in reference to neurosurgery.

Over the last few years, we have experienced a great change in the care and treatment of neurosurgical patients in the state of Florida. Because more than 95% of the neurosurgeons in Florida have been sued at least once we have been forced to practice a very different type of medicine than we used to. Although trial lawyers are fond of saying that the liability crisis is created by bad physicians, it is hard to believe that 95% of well trained, highly qualified neurosurgeons in Florida are incompetent.

The high risk of being sued and the excessive insurance premiums that neurosurgeons are paying in Florida have forced many excellent physicians to an early retirement, to limit their practice to medical treatment only, or to move out of the state. This same situation has also kept many young, brilliant neurosurgeons from coming to Florida and thus maintaining the state of the art up-to-date. In order to demonstrate my point of view I will give some specific examples.

Among five members of the staff of one of the medical schools in Florida, eleven million dollars have been awarded against them in malpractice suits.

The professor and chairman of another medical school is no longer performing surgery because of similar reasons. How can we accept that the professors who teach our future neurosurgeons are incompetent?

Dr. Leonard Mallis, a leading neurosurgeon in the United States who has made major contributions to the field of neurosurgery, has stated that patients with arteriovenous malformations of the spinal cord should not be treated in this country because of the high risk of legal implications.

The best medicine in any place in the history of mankind has been, and still is, being practiced in our country. It is therefore deplorable that our citizens must be sent away to receive the same or lesser treatment than in the United States because of our increasing concern with being sued.

In my community the neurosurgical manpower has diminished by 25% in the last year and in other cities by 40-50%, because of early retirements and moves of neurosurgeons out of the state. This is of course due to the above mentioned liability crisis.

As far as attracting new neurosurgeons to our community I can give the example of my own experience. Because of the early retirement of two of our associates, we have been actively seeking to recruit one or two new members. A very well-trained young neurosurgeon, native of Jacksonville and the son of a local physician who was interested in returning to his home town, elected to establish his practice in a different state because of the liability crisis in Florida.

Furthermore, due to the shrinkage of our group, we have had to limit our emergency coverage from six hospitals to only four.

Some of our colleagues in other areas of central Florida, (namely in Cocoa Beach and Ocala), not being so fortunate to be able to limit their practices, are being forced to be on call seven days a week around the year. It is, of course, unrealistic to expect that any doctor can fulfill such a demanding responsibility for an extended period of time.

As a compassionate human being, I am also extremely concerned by the effect that the professional liability crisis is having on the once sacred doctor-patient relationship.

For example, I can no longer put my hand over the shoulders of a grieving parent whose child I am about to operate on and give him comforting words, because that might be misinterpreted as a warranty of a successful result. Consequently, instead of being compassionate, I may come across as blunt and uncaring, while I am only trying to protect myself.

This kind of approach is very much against my idea of what a physician should be.

I would like to explain the devastating experience of a doctor enduring a malpractice suit. It can be compared to the effects of a bitter divorce. In both situations, a long-term stable bond has been broken, thus greatly affecting the partners as well as the future ones. A mutually trusting relationship has been destroyed.

I would like to share with you mine and others' experiences with a malpractice suit.

Several years ago I saw a patient from a nearby community whom I diagnosed as having an arteriovenous malformation of the brain. Because of the size and the location of the malformation, it was inoperable. The patient was suffering from severe headaches and, as it was well described by her neurologist and herself, she had a "time bomb ticking in her head ready to explode." The only possible available treatment was an embolization of the malformation. At that time, I was the only neurosurgeon with the required training and experience

who had performed this procedure in my community. Through the surgery, the malformation was reduced by 80%, her life was saved and her severe headaches disappeared. However, she developed a stroke with partial impairment of her left arm and leg. This patient sued me for three million dollars. The plaintiff's attorney wanted to settle the case for $1.5 million which was the limits of my insurance coverage. This was refused. A few days before the trial, my company lawyer received a threatening letter, with a copy addressed to me, stating that should we lose the case and the jury award should be above the limits of my insurance coverage, they will come for my personal assets. Unfortunately, in some cases in Florida this has occured, forcing the physician to file for bankruptcy.

Fortunately I won the suit. This meant one and a half years of "pain and suffering" for me, my family, my friends, and my patients. That also included a lot of trips around the country assisting my lawyer in taking depositions and one full week on court trial.

The state of Florida law clearly states that the losing party of a suit is responsible for all of the court expenses. However, that was not so in my case. I was advised by my attorney to relinquish such rights because the plaintiff's attorney had made the deal that, by doing so, they would withdraw their appeal. In any case, should I pursue that route, the patient would declare herself in bankruptcy and she will not pay anyway.

It was a nice 1981 Christmas present but it could hardly be considered a success story.

It is ironic that sometimes later, one of the plaintiff's attorneys called on me to treat his very sick father. Of course, I complied and fortunately, the patient is doing well now. However, the question in my mind remains. How come a man who earlier was questioning my competence as a neurosurgeon was later entrusting to me his father's life? Is the problem of the professional liability crisis due to poor quality doctors?

As an example of a frivolous suit, I will mention the following case. A 75-year-old man was operated for a brain tumor by an Ocala neurosurgeon. The outcome was good and the patient had no neurological deficit after the operation. However, later on, an infection occurred and the surgeon recommended a second operation. After consistently refusing the advised surgery, the patient finally went to Miami where he underwent the originally recommended procedure. He then decided to move to England. His 72-year-old wife, who remained in the United States, and her lawyer sued the Ocala neurosurgeon for $200,000 for "loss of consortion" due to a delay of the second operation.

The insurance company, without the surgeon's consent and without regard for the surgeon's reputation, decided to settle the case for $20,000 to avoid further troubles and costs. Of course, the neurosurgeon who had no say in this decision had his reputation forever damaged and his attitude forever changed.

And last, but not least of the problems I want to mention, the finanical implications of the liability crisis.

"Money is not the real problem."

I have learned that from my own patients. When a patient or a relative comes to me saying, "Doctor, do what you must because money is not the problem," it usually means that they are not going to pay anyway, therefore, "money is not the problem."

We, the neurosurgeons, can say the same thing. In spite of the fast rising insurance premiums (between $71,000 and $120,000 in 1986), money is not the problem because we are not going to pay it. The patients from Florida, through higher medical fees, will be the ultimate ones to pay. This could be hardly considered a way of reducing medical costs in Florida.

Should the day come when we, Florida neurosurgeons, could no longer afford to pay our insurance premiums, we will either decide to quit our surgical practice or to move to another state. This will, of course, be a tremendous loss of talent and investment for the community.

As a possible solution for this critical problem, the Florida Medical Association has endorsed capitation for pain and suffering awards; a limitation for contingency fees for lawyers, and a specification of the law in regards to joint and several liability.

I, as a neurosurgeon, can foresee that these bills, if passed, may alleviate the economical crisis and will be a step in the right direction. However, they will not solve completely the basic problem.

I have contacted many of the leading neurosurgeons of the state and all of us agree that the institution of mediation panels will eliminate most of the frivolous and fraudulent malpractice suits without interfering with the meritorious ones.

Such a mediation panel, composed of a physician, a lawyer, and an unrelated lay person, could make intelligent determinations of the merits of a law suit. Should a case be considered meritorious it could then be recommended for either a reasonable settlement or for a trial by jury.

I want to close my remarks by appreciating the opportunity to express my feelings and opinions in front of such an eminent group of U.S. Senators. This is a particularly great honor for me who, only 25 years ago, came to this land of liberty as a political refugee.

Given the opportunity, I have put all of my strength and efforts to work for our country and our profession, as well as to earn the respect of my fellow Americans.

Respectfully submitted,

Gaston J. Acosta-Rua, M.D., F.A.C.S.



When it comes to saving lives, teamwork becomes not only desirable; it becomes necessary.

In an operating room, in an emergency room, in consultation with other physicians, teamwork helps you do your job to the best of your ability.

The American Medical Association and your state and county medical societies believe in the value of teamwork — and the necessity of it, in the face of an increasingly complex professional environment.

We also believe that medical societies have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

For example, to keep government regulations from interfering with your practice, we effectively represent your interests at local and national levels.

To influence policies of organized medicine with which you disagree, we provide the means to have your views heard and respected.

And to keep you up to date on the latest medical advances, we publish JAMA, AM News, specialty, state, and county journals.

In fact, for all the times you can't operate alone, your medical societies will be there. Working with you to defend your rights and protect your freedoms.

Join Your Medical Societies Today.

For more information, contact your county or state medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name _____

Street _____

City _____ State _____ Zip _____

County _____

Book Review Editor — F. Norman Vickers, M.D.

Rx for the wounds of healing: the managerial imperative.

Healing the wounds

By David Hilficker, M.D., Pantheon Books, New York, 1985.

Dr. David Hilficker has written a splendid book, *Healing The Wounds*,[1] that should be read by all physicians. He describes poignantly the realities of the emotional stresses shared by all practicing physicians.

Dr. Hilficker worked as a family practitioner in a rural Minnesota community from 1975-1982. He practiced in a three-man clinic, 110 miles north of Duluth which served a county area of 1300 square miles and was populated by 4000 permanent and 20,000 summertime residents. His book is a processional of the frustrations, anxieties, sadness, fears, and crescendo exhaustion from constant calls that he experienced and that overwhelmed him during his practice years. Rural practice failed to provide Dr. Hilficker with the self-satisfaction and joy that many expect to derive from medicine. Instead, it stirred within him a continually accruing burden of emotional anguish. To Dr. Hilficker the practice of medicine was chronic scarification of personal emotional wounds. "Only by recognizing and accepting his or her own wounds can the healer minister to others. It is our wounds that make us human, that bridge the gap between patient and physician.

The book is a series of emotional explorations. Each chapter deals with a theme derived from experiences with one or more patient encounters. In one chapter he describes the overwhelming self doubt about his own clinical judgment and abilities that swelled within him after a patient, with a recent myocardial infarct, suddenly died a few hours after admissions to the hospital; in others he tells of the frustrations of never being able to answer the emotional demands of every patient who seems to need him, and the horrible sadness of having to tell the parents that their son has drowned.

He expresses the uncertainties and frightening discomfort that arise because of lack of "big city" medical facilities and consultative services and the oppression felt by the limitations presented by his own knowledge and training. He expresses the irritation at his patients who demand tranquilizers or antibiotics when such treatments are inappropriate and the guilt he suffers when he withholds antibiotics from an incompetent, elderly woman with pneumonia so that she can die peacefully. He even confesses to his own malpractice such as an incident in which he aborted a live fetus from a patient (who was also a family friend), after he had erroneously diagnosed its intrauterine death.

Each of us can trek along with Dr. Hilficker on his emotional odyssey. We have all dealt with many of the same type patients and situations that he displays. While reading we would like to exchange comments and our own stories with him. He is obviously a sympathetic and caring human being. The doctor he portrays to us is the ideal of every patient in America and the physician each of us superficially, would like to be. But he failed. He could not digest his emotional experiences and feed upon them to sustain his further growth. Instead they overpowered him and he had to leave the practice.

Most physicians share Dr. Hilficker's emotions and they can express and feel comparable compassion but they do so without being wounded by the experience.

The final chapter of his book and a recent *New York Times Sunday Magazine* article condemn the spiritual deflorescence of doctors by "bottom-line medicine."[2] He decries the medical neglect of the poor. He feels that doctors are overcompensated (he

currently cares for the sick in an inner city, indigent clinic from which he draws an annual salary of $22,000 plus lodging). He thinks it is inappropriate that a nurse or an office secretary should be paid less for an hour's work than a doctor. He draws attention to Jonsen's reminder that there have always been two different historical attitudes toward physician reimbursement: the first is the Greek Hippocratic tradition which stated that "medicine is a skill so rare that it can be sold at a great price. It is acquired with effort and it promises rewards." The second attitude is that practiced by medieval nuns and monks who felt it their duty to care for the ill without compensation.[3] Dr. Hilficker express his kinship with the ascetic precedent of the nuns and brothers.

The reading of Dr. Hilficker's book and *New York Times* article leaves us troubled and self-condemning. Both works elicit a nostalgic resurrection of the ideals that attracted most of us into medicine. Selflessness, compassion, the auto-adulatory sensation that one is serving humanity, blended in with the scientific wizardry and the technological rituals of modern medicine, are the ingredients for an intoxicating brew. We have all quaffed this potion but the aftereffects have transformed us into creatures other than the types that we had pictured for ourselves in our idealistic youth. Dr. Hilficker perhaps imbibed too much and experienced a hangover that was destructive: severe burnout and copout. Yet many of us yearn and strive for the ideals that Dr. Hilficker expresses: one in which we can attend only to our patients, resolve all their problems, and then retire at the end of the day to the comforts of family and friends.

Would it not be wonderful if we were not burdened by the econmic responsibilities of medicine, and were not required to constantly balance the costs of procedures, medications, and hospitalization with the needs of our patients? Would it not be delightful if we only had to care for five to ten patients each day and satiate the entirety of their medical and emotional appetites in a thorough and totally competent fashion? Would life not be splendid if we were not continually stressed by Dr. Hilficker's dilemmas which offer us no comforting resolution? Why have we been transfigured from that self-image of the quixotic medical monastic who denies his own human cravings into Hilficker's rendition of the narcissistic 1980's physician who excessively concerns himself with his own creature comforts, overhead, insurance companies, and Medicare? Should we flagellate ourselves because our professional souls no longer tingle with the enthusiasm and excitement that titillated us during our formative years as medical students and house officers?

For several weeks after reading Dr. Hilficker's book and article I wrestled with these questions. They bother all doctors. I feel that the resolution to Dr. Hilficker's dilemmas is that his assumptive world about medicine is warped. The version of Dr. Hilficker's physician differs as starkly from the 1980's practitioner as a Jackson Pollack abstract differs from recognizable reality. The complexities of modern American medicine do not permit physicians to function as medical monastics resistant to the contorting economic tensions that reticulate today's society. Medicine is not simple and will not allow a doctor to be a simple bedside healer who is disentangled from the financial concerns of providing medical care. Doctors are, must be, and probably always have been, managers.

The concept of the doctor as a manager is offensive to many of us. The word "manager" conjures up the negative image of a medical businessman and the stigma attached to entrepreneurialism within medicine. We speak of "managing patients," yet we never brood over the true meaning or implications of the word "management." Most have never peeked into a basic textbook on management even though management is what we do. The work of managers is to recruit, organize, collate, and focus the activity of others towards a common goal. Our common goal is patient care. Each decision we make every day fulfills the definition of management. The orders we write in hospital chart affects the activities of nurses, technicians, pharmacists, aides, secretarial staff and other professionals who focus on the care of our patients. In our offices, we similarly affect the activities of those who work for us. Our decisions also affect the lives and activities of our patients and their families. Not only do our decisions affect the activities of human beings other than ourselves but our decisions are economic in nature.

We cannot evade the financial implications of our decisions. A single order that we write can summon into action millions of dollars of technology and expend thousands of dollars of medical resources. Doctors, as a group, are directly responsible for spending $280 billion (or an average of over a half million dollars per physician per year) of the public's economic resources. Our decisions impinge upon third party payors and their employees, government bureaucrats and legislatures. To the critically ill patient we are more important than the chief executive officer of a major corporation. If the CEO fails the corporation declares bankruptcy. If we fail, the patient may die. Doctors are managers in every sense of the twentieth century meaning of the word.

Since doctors are managers their worth as managers must be acknowledged by society. For Dr. Hilficker to decide that physicians should be paid commensurate with a nurse or receptionist is egalitarian naivete. Egalitarian experiments in society have been tried and all have failed. They fail because they cannot fulfill their promises because human nature is not homogenized. Individuals vary in their willingness to work, their energy level, their aspirations, their intelligence, and their talent. Stratificaton of people and the need for managers or leaders in

society is reality no matter how primitive the society. Since inequality is the reality, then value will be adjudicated and assigned to each stratum and remuneration parceled out accordingly.

Andrew Grove has stated that the foremost quality of a successful manager is the possession of a clarity of purpose.[4] The successful manager must have a vivid image of what is to be done and how it is to be accomplished. The manager has to focus his attentions on a limited number of goals at any one moment. He must recognize that he is in command and that he is leading. To be so focused a manager must channel his energies, prioritize his duties and compartmentalize problems. He must do this for himself and for the people that respond to him. The doctor who fails to recognize the managerial process brings on disorder for himself and for others.

Dr. Hilficker was obviously not a manager. He had great difficulty compartmentalizing and prioritizing his needs and those of his patients. He attempted to lower his patient volume so that he could spend more time with each individual but this failed to resolve his problems. It failed to assuage his guilt over his own inadequacies. His major flaw was his lack of clarity of purpose. He thought that he could be everything to every one of his patients. As a family practitioner he felt that he had to take on all their medical care, and resolve all their psychologic as well as all their medical needs. This was impossible and failure followed. He did not focus. He did not ask the important questions: what are the most important medical and psychosocial needs of the members of the community who use me as a doctor? How can I best function in a situation that is limited by time and available resources? How much time should be allotted to individuals with given medical problems? By increasing time input, will I proportionately increase the health output for the patient? Or will greater input of my time result in little real increase in the value of my services to that patient and subsequently a reduction in the value of my services to the needs of the community at large? Nowhere does Hilficker recognize or address these issues. He, like all of us, was not educated in managerial concepts. He was ensnared by the commonly promulgated medical school delusion that the ideal physician can treat all the problems of all his patients. When Dr. Hilficker realized he could not live by this ideal, he became guilt ridden, frustrated, depressed, and was forced to abandon his practice.

Dr. Hilficker attributes many of his, and medicine's woes, to the current day "business" influence in medicine. But he again is wrong. The necessity for applying managerial style organization to the doctor's daily activities was preached to medical students eighty years ago by William Osler. Osler recognized the complexities of the lives of physicians and wrote of these in his delightful monograph "Aequanimitas."[5] Osler stressed the importance of compartmentalizing our activities. He told us that each day had to be divided into highly specialized segments. When the mental concerns that belong to the activities of one time segment haunt us during the performance of duties within another segment then stress, guilt, immobility, and inefficiency follow. Dr. Hilficker and many others failed to grasp this principle. Osler did not require that we adapt the demeanor of robotic automatons; rather he declared that permitting the intrusion of extraneous concerns into one's consciousness prohibits us from performing our currently assigned task well.

Many physicians fail to compartmentalize and prioritize their work. They do not ask, "what are my duties as a doctor?" Most physicians would answer this query by stating that our duties are to optimally utilize our medical talents and training to resolve the health needs of our patients. Our talents as physicians reside in our ability to take histories, examine our patients, formulate diagnoses, utilize the appropriate technology efficiently, and then perform procedures, and render patient treatment and decisions. These are managerial type decisions. These are what we are trained to do. Yet most physicians spend a majority of their time writing chart notes, history and physicals, hospitals notes, prescriptions, etc. They are not managing; they are working as scribes. Two decades ago Lawrence Weed, M.D., convinced most academic center physicians and their graduates that the alignment, organization, and appearance of the chart note determines the quality of the physician. What nonsense! Patient outcome should be the mark of a good physician. Chart messages can be formed by an assistant. Notes that take ten minutes to write can be dictated in thirty seconds or less. Better yet computer generated notes, that can amount for 80% of the common illnesses that enter into a physician's office, require less than 15-20 seconds of physician input. As a physician our major resource is our time. Successful managers employ time efficiently.

Patients come to us for very few reasons. They want to "get well," be assured that they are well, or obtain some relief of their discomfort. We need to respond to their needs but we must respond in a responsible and economically streamlined fashion; to do this, we must first become competent managers. Perhaps this is the lesson that is best derived from Dr. Hilficker's book. He does not recognize why he failed, only that he did fail. To him medicine is at fault. In reality his abilities as a manager and perceptions of the essence of American medicine are at fault.

References

1. Hilficker, D: Healing the Wounds: A Physician Looks at His Work, Pantheon Books, New York, 1985.
2. Hilficker, D.: A Doctor's View of Modern Medicine, The New York Times Magazine, February 23, 1986.
3. Jonsen, A.R.: Watching the Doctor, New England J. Medicine, 308:1533, 1983.
4. Grove, A.: Tapping Into the Leader Who Lies Within Us, Wall Street Journal, April 7, 1986.
5. Osler, W.: The Master Word in Medicine, In Aequanimita, With Other Addresses to Medical Students, Nurses, and Practitioners of Medicine, Blakisten, Philadelphia, 1948, p. 349-371.

Jacques R. Caldwell, M.D.
Daytona Beach

- Dr. Caldwell practices Rheumatology in New Smyrna Beach and Daytona Beach.

This space contributed as a public service.

YOU CAN FIGHT CANCER BEFORE YOU GET IT.

OR AFTER YOU GET IT.

It's a lot easier to fight cancer before you get it.

Scientists estimate that up to 60% of all cancer could be prevented.

By simply making a few changes in your lifestyle.

By not getting too much sun. By not smoking cigarettes. By not overeating. And by following a diet high in fiber and low in fat.

By simply doing these few things, you could drastically reduce your risk of getting cancer.

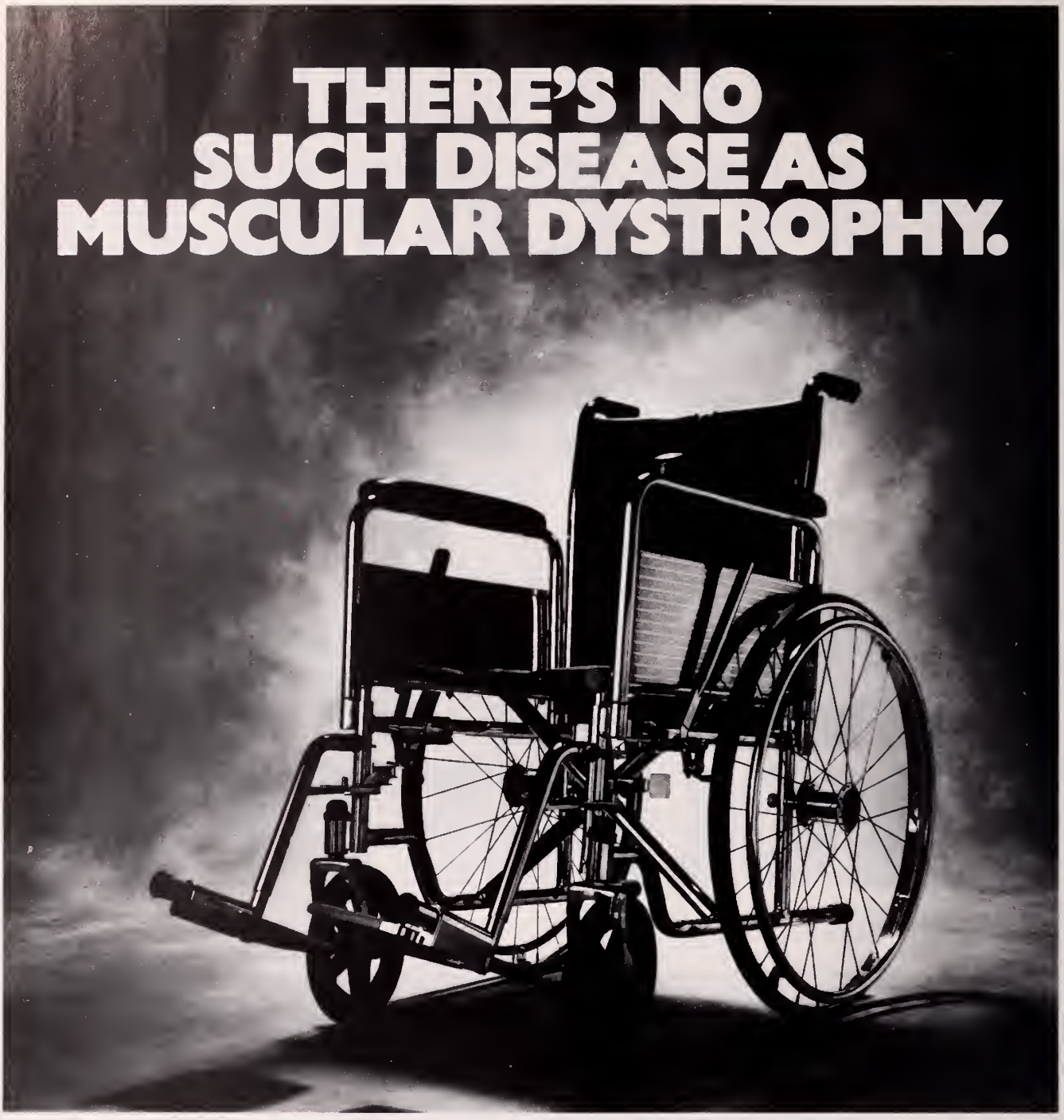
Sure, you could still get cancer.

But why not give yourself the odds against it?



Help us keep winning.

THERE'S NO SUCH DISEASE AS MUSCULAR DYSTROPHY.



It's true. Because "muscular dystrophy" is the term for a *group* of twelve diseases—and no one disorder goes by that name.

Other facts about muscular dystrophy might surprise you, too. For one thing, the diseases aren't restricted to children. Anyone can be stricken, at any time.

For another thing, the Muscular Dystrophy Association battles not just the twelve muscular dystrophies, but twenty-eight other neuromuscular diseases, too.

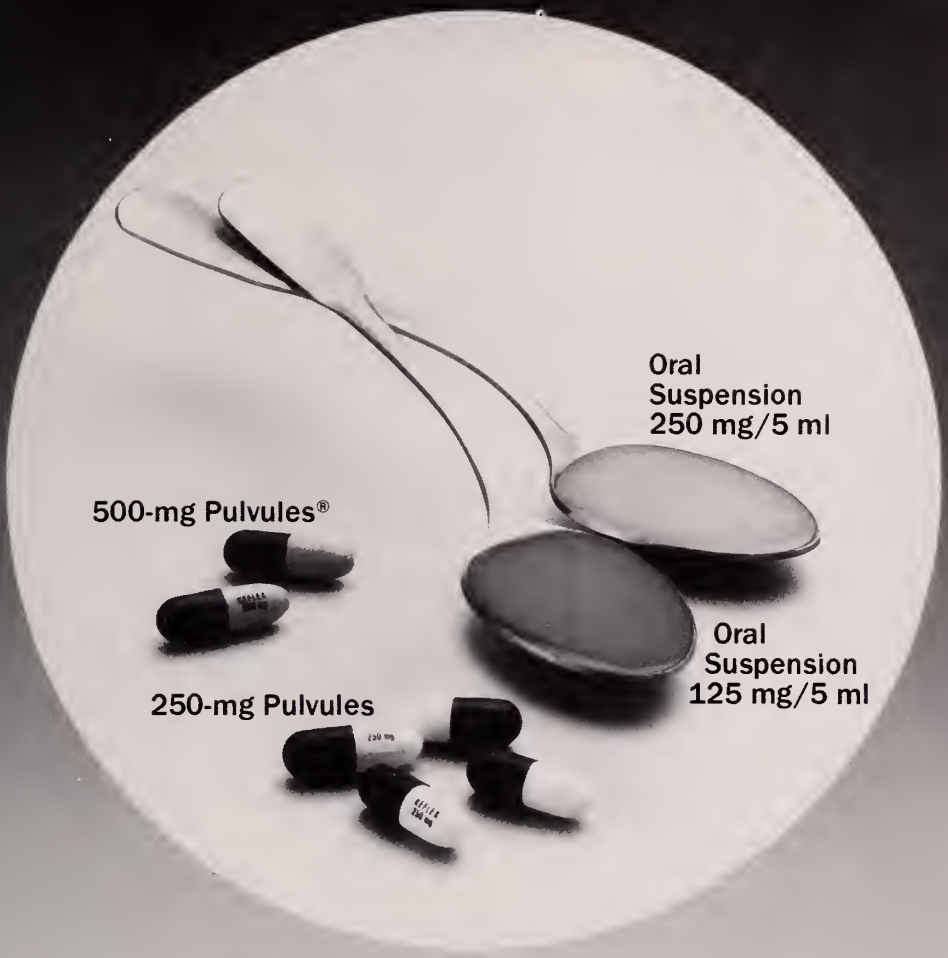
At MDA, we're striving to put an end to all the devastating disorders you used to think of as muscular dystrophy.

And one day—we're determined—this chair will be empty for real.

MDA

Muscular Dystrophy Association, Jerry Lewis, National Chairman

Easy To Take



Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA

420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions*.) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

Knoll Pharmaceuticals
A Unit of BASF K&F Corporation
Whippany, New Jersey 07981

BASF Group

knoll®

EMPLOYEES APPRECIATE THE PAYROLL SAVINGS PLAN.

JUST ASK THE PEOPLE AT THE BOEING COMPANY.

"My folks gave me a Bond for my birthday every year. Now I can do the same for my kids."
—Vaughn Hale



"It's certainly a painless way to save. The money comes directly out of my paycheck every two weeks."
—Florence Perry



"This is one way I can support my government and save at the same time."
—Douglas Scribner



U.S. Savings Bonds now offer higher variable interest rates *and* a guaranteed return. Your employees will appreciate that. They'll also appreciate your giving them the easiest, surest way to save.

For more information, write to: Steven R. Mead, Executive Director, U.S. Savings Bonds Division, Department of the Treasury, Washington, DC 20226.



U.S. SAVINGS BONDS
Paying Better Than Ever

A public service of this publication.

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Acquaint yourself with Auxiliary programs

When you, the physician, are confronted with problems in your practice and are wondering where, what, and why. . .think of the FMA Auxiliary. . .and their programs in your community. You can be the catalyst to generating more public awareness of these programs in you community. If each physician would take just a few minutes to acquaint himself, or herself, with the programs in his, or her, area, just think of the goodwill that could be created.

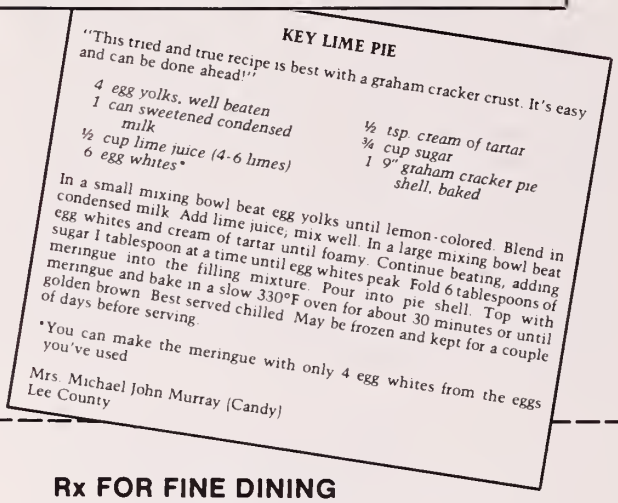
The President of the Florida Medical Association Auxiliary, Jo Tignor, stated at the beginning of her presidency, "Our single primary goal for the year is to let our communities know that 'we care' about all that affects the well-being of every man, woman, and child." Auxiliary programs reflect that goal.

Our successes include: Broward County — funds for Allied Health, Children's Home, Migrant workers, Boy Scouts, Jackson Memorial Hospital, Ronald McDonald House, Asthamatic Camps, and Board of Education; Dade — funds for Child Abuse Prevention programs; Duval — funds for nursing scholarships; Escambia — funds for the dining room at the Ronald McDonald house, car seats to local hospitals; Hernando — drug abuse prevention programs; Indian River — hot meals each Saturday for the Spouse Abuse Shelter and distribution of personal hygiene kits to the spouses; Lake — published a cookbook to benefit Health Careers Scholarships; Lee — benefit Children's Home and Counseling Center for which they received "Quality of Life Award" from *Gulfshore Life Magazine*; Hillsborough — funds for nursing scholarships; Marion and Orange — active in programs for the elderly, mental health, and child abuse; Palm Beach — published a resource guide, "Enjoying Life in Favorite Ways;" Pinellas — seminars on health careers, teach C.P.R.; Sarasota — teach C.P.R. (2,000 ninth grade students); Polk — blood drive honoring their doctors on Doctors' Day; Volusia — teach sex education to students, Toddler Seat Program and Spouse Abuse Centers.

This is but a fraction of the many programs in which Auxiliaries are participating. The Auxilian of today is a caring, compassionate, individual who is willing and able to demonstrate to our respective communities that "We Care!"

Mrs. Carl (Tommy Jean) Redderson
County News Editor
The Quarterly
St. Petersburg





KEY LIME PIE

"This tried and true recipe is best with a graham cracker crust. It's easy and can be done ahead!"

4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice, mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used

Mrs. Michael John Murray (Candy)
Lee County

Rx for fine dining.

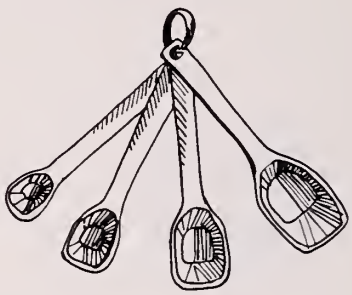
—A collection of over 700 gastronomical delights.

—Eight sections from appetizers to desserts - including many outstanding game, seafood and sauce recipes.

—Full color cover with original pen and ink illustrations dividing the sections.

—Spiral bound and indexed with menus, helpful hints and potpourri.

—Compiled by the Florida Medical Association Auxiliary for the benefit of health related projects.



Rx FOR FINE DINING
P.O. Box 2411
Jacksonville, FL 32203

Please send me _____ copies of Rx For Fine Dining at $10.00 per copy plus $1.30 for postage and handling. Florida residents add $.50 sales tax.

Make checks payable to — COOKBOOK PROJECT, FMA-A
P.O. BOX 2411
JACKSONVILLE, FL 32203

Name _____

Address _____

City, State, Zip _____

COOKBOOKS MAKE GREAT GIFTS!

"Deafness is something you put beside you not in front of you."

LINDA BOVE / ACTRESS



PHOTO: HELEN NESTOR

Linda Bove performed with The National Theatre of the Deaf for nine years. She has also starred in the Tony Award winning show, *Children of a Lesser God*.

Believe in them. Break the barriers.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, WASHINGTON D.C. 20210

PRODUCED BY THE SCHOOL OF VISUAL ARTS PRESS, LTD.

Deaths

ADAMS, JOHN POWELL, Panama City; born 1914; Tulane University, 1938; member AMA; died 1986.

ANDERSON, WILLIAM, Miami; born 1910; University of Toronto, 1934; member AMA; died 1/20/86.

ARNOULT, MATHEW BLAKE, Rockledge; born 1913; University of Tennessee, 1943; member AMA; died 4/19/86.

ATKINSON, HORACE D., West Palm Beach; born 1917; Emory University, 1942; died 12/26/85.

BARNES, ASA, Fernandina Beach; born 1904; University of Tennessee, 1931; member AMA; died 2/21/86.

BARNES, LOY J., Miami; born 1929; University of Missouri, 1957; member AMA; died 1985.

BECK, GERHARD THEODOR, McLean, Virginia; born 1908; University of Vermont, 1945; member AMA; died 1985.

BERLIEN, IVAN C., Coral Gables; born 1908; Wayne University, 1937; member AMA; died 7/7/85.

BLANK, RICHARD HARROD, Tampa; born 1928; Cornell Medical, 1953; member AMA; died 12/31/85.

BROWN, VAN M., Miami; born 1906; Tufts University, 1930; member AMA; died 6/85.

BURNS, JOSEPH, Miami; born 1902; Boston University, 1928; died 11/26/85.

CALLEN, IRWIN R., Miami; born 1919; University of Illinois, 1943; member AMA; 4/18/86.

CARTER, GERARD F., Miami; born 1912; Royal University of Genoa, Italy, 1938; member AMA; died 3/3/86.

CELLA, CHARLES F., Pompano Beach; born 1906; University of Bellevue, 1931; member AMA; died 8/11/85.

CENTURION, MANUEL, Miami; born 1930; University of Havana, 1955; died 1/6/86.

COGAN, MICHAEL A., Miami; born 1908; Vanderbilt University, 1936; member AMA; died 2/17/86.

DE VICTORIA, WILLIAM L., Miami; born 1930; Georgetown University 1956; died 1985.

DEWOODY, GERALD, M., West Palm Beach; born 1901; Michigan University, 1930; member AMA; died 10/10/85.

DILLON, LOWELL, O., Bradenton; born 1912; Ohio State University, 1941; died 12/5/85.

DOZIER, LAURIE L., Tallahassee; born 1900; University of Georgia, 1924; member AMA; died; 1/22/86.

ELIAS, JUAN J., Miami; born 1931; University of Havana, 1957; died 1/7/86.

FELDER, MICHAEL, Miami; born 1928; State University of New York, 1955; died 1/4/86.

FRADE, ACELA, Miami; born 1918; Havana School of Medicine, 1946; died 1985.

FRASER, DONALD S., Tallahassee; born 1896; McGill University, 1924; member AMA; died 1/86.

GARCIA-TOJAR, JOSE, Miami; born 1913; University of Havana, 1943; died 1985.

GROS, JOSE C., Miami; born 1901; Havana University Medical School, 1923; died 4/11/86.

GROSSMAN, LEO, Miami; born 1911; New York Medical, 1936; died 4/20/86.

GUNDERSEN, GEORGE O., Waterloo, WI; born 1895; State University of Iowa, 1924; member AMA; died 11/29/85.

HAGAN, V. LEROY, Clearwater; born 1911; Tulane University, 1939; died 3/25/86.

HEATH, RALPH T., Tampa; born 1903; University of Georgia, 1933; member AMA; died 12/27/85.

HECHT, ROY ADOLPH, Altamonte Springs; born 1919; Chicago Medical, 1945; member AMA; died 4/28/86.

HLIVKO, ALEXANDER E., Inverness; born 1923; University of Cincinatti, 1955; died 3/21/86.

HODGE, MAURICE, Rockledge; born 1913; University of Tennessee, 1959; member AMA; died 5/9/86.

HOUSTON, JACK M., Miami; born 1902; Northwestern, 1924; member AMA; died 10/27/85.

KNIGHT, CLAUDE M., Palatka; born 1909; Emory, 1934; died 11/24/85.

KNOWLTON, HORACE A., JR., Tampa; born 1906; John Hopkins, 1932; died 7/18/85.

KUCKKU, MORRIS, Miami; born 1907; Northwestern, 1937; died 1985.

LAMSTEIN, JACOB, Miami; born 1903; University of Maryland, 1928; member AMA; died 5/22/85.

LEVINE, LOUIS, St. Petersburg; born 1906; University of Glasgow, Scotland, 1935; member AMA; died 8/12/85.

LILL, FRANK JOSEPH, Daytona Beach; born 1931; University of Ottowa, 1959; died 11/22/85.

MATINEZ-LOPEZ, REINALDO, Miami; born 1913; University of Havana, 1940; died 5/25/86.

McANDREW, JOHN J., Orlando; born 1913; Georgetown Medical School, 1937; member AMA; died 2/5/86.

McCARTHY, ALPHONSUS M., Daytona Beach; born 1899; University of Tennessee, 1925; member AMA; died 11/17/85.

McCHESNEY, WILLIAM WALLACE, Gainesville; born 1891; Medical College of Virgina, 1915; died 2/14/86.

McCLOSKEY, PAUL J., Tampa; born 1918; University of St. Louis, 1944; member AMA; died 1/29/86.

McEWAN, DUNCAN T., Orlando; born 1902; Cornell University, 1928; member AMA; died 10/14/85.

McKAY, ERNEST G., Jacksonville; born 1923; Temple University, 1948; member AMA; died 5/10/85.

McKEE, THOMAS L., Ft. Lauderdale; born 1902; Iowa University, 1928; member AMA; died 2/14/84.

McSWAIN, GEORGE HOWARD, Daytona Beach; born 1917; Vanderbilt, 1941; member AMA; died 12/4/85.

MIDKIFF, CARL MERLIN, Miami Shores; born 1911; Iowa University, 1943; member AMA; died 5/3/85.

NICGORSKI, EUGENE J., Middleton, MA; born 1906; Boston University, 1931; died 8/25/85.

PECK, LEATRICE KATZ, South Miami; born 1923; New York Medical, 1947; member AMA; died 1985.

PEISNER, FRED ALAN, Orlando; born 1936; University of Miami, 1962; died 6/3/86.

RAMIREZ, JOSE, St. Petersburg; born 1928; Universidad Nacional, Bogota, Colombia, 1954; died 7/8/85.

RENTZ, BILLY, Miami; born 1923; Emory, 1947; died 1985.

ROQUE, DORA CLARA, Jacksonville; born 1940; University of Sevilla Medical School, Spain, 1965; died 11/8/85.

ROIG, GUILLERMO, Miami; born 1894; University of Havana, 1924; died 1985.

SACKETT, WALTER, Miami; born 1905; Rush Medical College, University of Chicago, 1938; died 1985.

SCHOETKER, GEORGE, Clearwater; born 1903; St. Louis University 1930; member AMA; died 3/29/85.

SELTZER, BERNARD B., Hollywood; born 1914; University of Toronto, 1938; member AMA; died 10/31/85.

SILVERMAN, IRVING, West Palm Beach; born 1904; member AMA; died 1986.

SIMPSON, SHIRLEY R., Port St. Joe; born 1933; University of Florida, 1965; died 10/22/85.

SMITH, JOSEPH H., Vero Beach; born 1914; Hahnermann, 1937; member AMA; died 9/11/85.

SPONDER, LEONARD, Deerfield Beach; born 1939; University of Basle, Fac. of Medicine, 1968; died 12/15/85.

THOM, CHARLES H., West Palm Beach; born 1912; New York Medical College, 1941; member AMA; died 11/20/85.

THOMPSON, JAMES EDGAR, Tarpon Springs; born 1912; Ohio State University, 1935; member AMA; died 3/22/86.

TRYGSTAD, ETHEL, Naples; born 1903; Columbia University, 1927; member AMA; died 2/86.

WATTLES, WALDO, M., Ocala; born 1911; Vanderbilt, 1936; member AMA; died 12/1/85.

WEISBERG, ABRAHAM, ALLEN, West Palm Beach; born 1905; Wayne University, 1931; member AMA; died 4/22/85.

WENTZELL, JAMES EARL, Tampa; born 1910; Jefferson Medical University, 1937; died 3/20/86.

WEXLER, HOWARD ALLEN, Ft. Lauderdale; born 1940; University of Rochester, 1967; died 1/30/86.

WHITE, HENRY CLAY, Fort Walton Beach; born 1913; Tulane, 1939; died 4/28/86.

WHITMER, KENNETH, Miami; born 1910; Ohio State, 1936; member AMA; died 11/14/85.

WILCOX, ABBOT Y., JR., St. Petersburg; born 1904; University of Pennsylvania, 1930; member AMA; died 11/25/84.

WRUBEL, NORMAN N., Hollywood; born 1922; Long Island College, 1946; member AMA; died 10/26/85.

GET MORE FOR YOUR ADVERTISING DOLLAR

Purchase A Display Ad in the

Journal of the Florida Medical Association, Inc.

Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203

(904) 356-1571



Imagine waking up with painful stomach cramps.

Imagine going through your day with terrible diarrhea.

Now imagine those painful, embarrassing symptoms never going away.

That's what people with Ileitis and Ulcerative Colitis endure every day.

Over 2 million men, women and children suffer with these devastating intestinal diseases. That's more than Muscular Dystrophy and Cerebral Palsy combined.

Yet as widespread as Ileitis and Ulcerative Colitis are, they're just as misunderstood.

Some people think these diseases are only in your mind.

They're not.

Some people think they come from eating the wrong kinds of foods.

They don't.

Some people even laugh at the symptoms.

They shouldn't.

Because Ileitis and Ulcerative Colitis can strike at any age, at any time. And there's no known cause. Or cure.

If you can imagine yourself enduring this kind of pain, you know why we need your help.

And why we need it now.

The National Foundation for
Ileitis & Colitis

To send your tax-deductible contribution or for more information, please write N.F.I.C., P.O. Box 2020, Murray Hill Station, New York, NY 10156

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

29 Glen Cove Ave., Glen Cove, N.Y. 11542 516-676-4300

Our members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
American Health(10)	14.95	12.95	11.95	
American Heritage(6)	24.00	18.00	18.00	
Amer.Photographer(12)	19.90	9.95	6.65	8
Americana(6)	11.95	11.95	9.95	
ArtNews(12)	29.95	25.95	25.95	
Artist's Mag(12)	21.00	21.00	9.97	9
Atlantic Monthly(12)	9.95	9.95	9.95	
Audio(12)	17.94	8.97	8.97	
Baseball Digest(12)	14.95	14.95	7.97	10
Basketball Digest(8)	9.95	9.95	7.97	
#Better Hms-Gdns(12)	12.97	6.49	12.97	
#Bicycling(10)	15.97	8.00	12.97	
Black Enterprise(12)	15.00	9.00	7.50	
Bon Appetit(12)	15.00	15.00	15.00	
Boys Life(12)	13.20	13.20	11.97	
Car & Driver(12)	17.00	11.99	11.99	
Cats (12)	17.50	17.50	12.50	
Cat Fancy(12)	17.97	17.97	12.97	
Changing Times(12)	15.00	9.97	9.97	
Child Life:age 6-10(8)	11.95	11.95	9.97	
Childrens Dig:7-11(8)	11.95	11.95	9.97	
Commentary(12)	33.00	33.00	33.00	
#Connoisseur(12)	19.95	10.00	19.95	
Consumers Digest	14.97	14.97	10.97	
Consumers Reports(12)	16.00	16.00	16.00	
#COSMOPOLITAN(12)	**24.97**	**15.00**	**24.97**	
Cruising World(12)	18.00	18.00	14.00	
#Discover(12)	24.00	13.00	14.95	
Dog Fancy(12)	17.97	17.97	12.97	
Downbeat(12)	15.75	15.75	7.95	
Ebony(12)	16.00	14.00	9.97	
The Economist(52)	85.00	51.00	51.00	
Ellery Queen Myst(13)	22.75	19.50	9.97	10
Esquire(12)	17.94	9.95	9.95	
Essence(12)	12.00	9.96	9.00	
Family Circle(17)	14.97	14.97		
Family Computing(12)	19.97	11.97	11.97	
Family Handyman(10)	9.95	9.95	5.95	
Field & Stream(12)	13.94	7.94	7.94	
Fifty Plus(12)	15.00	11.97	11.97	
Financial World(26)	41.95	24.94	18.95	18
Food and Wine(12)	18.00	9.00	15.00	
Football Digest(12)	12.95	12.95	7.97	10
Forbes(28)	42.00	42.00	28.00	
Fortune(26)	42.00	21.00	21.00	
Games Magazine(12)	15.97	15.97	15.97	
Gentlemens Quart.(12)	18.00	13.50		
Glamour(12)	15.00	12.00		
Golf Digest(12)	19.94	11.97	11.97	
Golf Magazine(12)	15.94	8.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Good Housekeeping(12)	14.97	9.97	14.97	
Gourmet(12)	18.00	13.50	15.00	
#Harpers Bazaar(12)	16.97	8.97	16.97	
Harpers Magazine(12)	**18.00**	**9.97**	**9.97**	
Health(12)	22.00	13.32	11.00	
High Fidelity(12)	13.95	6.98	6.98	
Home(12)	15.00	15.00	15.00	
Home Mechanics (12)	11.94	8.97	8.97	
The Homeowner(10)	18.00	13.97	9.00	
Hot Rod(12)	13.94	8.97	8.97	
House and Garden(12)	24.00	18.00		
#House Beautiful(12)	15.97	7.99	15.97	
Humpty Dumpty:4-7(8)	11.95	9.97	9.97	
Jerusalem Post(24)	18.46	18.46	15.97	
Jet(52)	36.00	30.00	26.00	
Ladies Home Jrnl(12)	20.00	15.00	10.00	
#Life(12)	32.50	16.25	25.00	10
M:Civilized Man(12)	24.00	19.95	17.95	10
Mademoiselle(12)	15.00	12.00		
#McCalls(12)	11.95	11.95	11.95	
Metropolitan Home(12)	15.00	7.50	7.50	
Modern Photography(12)	13.98	7.98	6.99	
#Muney(12)	29.95	15.00	19.95	
Mother Jones(12)	18.00	12.00	12.00	
Motor Trend(12)	13.94	7.97	7.97	
MS Magazine(12)	16.00	10.97	10.97	
The Nation (52)	28.00	28.00	9.95	24
Nation's Business(12)	22.00	12.97	12.97	
Natural History(12)	20.00	15.95	15.95	
N.E.Journal of Medicine(52)	60.00			
New Republic (52)	48.00	48.00	28.00	
#New Shelter(9)	10.97	5.50	9.97	
N.Y. Rev.of Books(17)	28.00	28.00	25.95	
New Yorker(52)	32.00	32.00	20.00	
#Newsweek(52)	41.00	21.80	21.80	
Omni(12)	24.00	15.96	15.96	
1001 Home Ideas(12)	22.00	15.97	11.00	
Organic Gardening(12)	12.97	9.97	9.97	
Outdoor Life(12)	13.94	7.97	7.97	
Outside(10)	16.00	12.00	8.97	
Ovation(12)	16.00	8.00	8.00	
PARENTS(12)	**18.00**	**9.00**	**11.95**	
Penthouse(12)	36.00	30.00	30.00	
People(52)	56.50	56.50	28.25	
Personal Computing(12)	18.00	18.00	8.97	9
Petersens Photog(12)	13.94	6.97	6.97	
Playboy(12)	25.00	21.50	21.50	
#Popular Mechanics(12)	13.97	7.00	13.97	
Popular Photogr.(12)	11.97	5.99	5.99	
Popular Science(12)	13.94	7.97	7.97	

PUBLICATION (No. of iss. per yr)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE	(No of iss)
#Prevention(12)	13.97	7.00	13.97	
Psychology Today(12)	15.99	8.00	12.97	
Reader's Digest(12)	15.41	15.41	15.41	
#Redbook(12)	11.97	6.97	11.97	
Road and Track(12)	17.94	11.99	12.99	
Rolling Stone(26)	19.95	19.95	17.95	
The Runner(12)	16.97	12.97	8.97	
#Runner's World(12)	19.95	10.00	12.97	
Sail(12)	21.75	21.75	21.75	
Saturday Eve.Post(9)	12.97	12.97	12.97	
Savvy(12)	12.00	12.00	6.00	
Science '86(11)	18.00	18.00	13.95	
#Science Digest(12)	13.97	6.99	13.97	
Scientific Amer.(12)	24.00	24.00	24.00	
Self(12)	15.00	12.00	N.A.	
Seventeen(12)	13.95	13.95	13.95	
Shape(12)	20.00	20.00	8.97	6
Ski(8)	11.94	6.97	6.97	
Skiing(7)	9.98	4.99	4.99	7
Skin Diver(12)	13.94	7.97	7.97	
Sport(12)	12.00	7.97	7.97	
Sporting News(24:6 mo)	22.50	11.97	11.97	
#Sports Afield(12)	13.97	6.99	13.97	
#Sports Illustr.(54)	56.50	34.00	29.45	
Stereo Review(12)	9.97	4.99	4.99	
Teen(12)	12.95	7.95	7.95	
Tennis(12)	17.94	8.97	8.97	
#Time(52)	58.25	29.25	28.00	50
#Town & Country(12)	24.00	12.00	24.00	
Travel & Leisure(12)	25.00	12.50	25.00	
TV Guide(52)	31.20	31.20	26.00	
#U.S.News/Wrld.Rep(52)	41.00	20.50	20.50	
Vegetarian Times(12)	19.95	14.95	14.95	
Video(13)	15.00	15.00	7.50	
Video Review(12)	12.00	6.97	6.97	
Village Voice(52)	32.76	32.76	22.00	
Vogue(12)	24.00	21.00		
W Magazine(26)	26.00	23.00	17.95	
Weight Watchers(12)	13.97	11.97	11.97	
Woman's Day(17)	15.13	15.13	15.13	
Women's Sports(12)	12.95	12.95	8.95	
Workbench(6)	6.00	6.00	5.00	
Working Mother(12)	11.95	9.95	9.95	
Working Woman(12)	18.00	12.00	15.00	
World Press Review(12)	16.95	16.95	14.98	
Writer's Dig.(9 iss)	18.00	9.97	9.97	
Yankee (Colonial)(12)	15.00	15.00	12.97	
YM(12)	14.00	10.95	10.95	

#BUSINESS CARD NEEDED FOR OFFICE PRICE				

HUNDREDS OF OTHER TITLES AVAILABLE! PLEASE SEND US YOUR REQUESTS!

FMA MAGAZINE PROGRAM
29 Glen Cove Ave., Glen Cove, N.Y. 11542

MAIL MAGAZINES TO:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AFFILIATED HOSPITAL/SCHOOL _____
Required for Educator rates

VISA or M/C No. _____ Exp. Date _____

Prices subject to publishers' changes.

PLEASE SEND THE FOLLOWING MAGAZINES:

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

All subscriptions are for one year unless otherwise noted
Guarentee: Our prices are the lowest, our service the best.
New Orders: Publishers take from 6 to 12 weeks to start your subscription
Renewels: Please send the address label from your magazine at least 8 weeks in advance of expiration date.

Please make checks payable to: FMA Magazine Program

FLMD186

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

AUGUST

ACLS Course, August 1-3, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Second Annual Controversies in Carcinoma of the Breast, August 6-9, Hyatt Regency, Orlando. For more info: Dr. Bramson, (813) 974-2538.

Basic Trauma Life Support, August 8-9, USF College of Medicine, Tampa. For more information: James Hillman, M.D., (813) 251-6911.

Second Annual Laser Surgery Training Course, August 12-16, Wyndham Hotel, Orlando. For more information: Patti Devlin, 1414 South Kuhel Avenue, Orlando 32806-2093, (305) 841-5144.

Pediatric-Oriented Advanced Cardiac Life Support, August 22-24, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Strategic and Operational Survival Plans for Office Based Physicians, August 22-24, Orlando Hyatt Hotel, Orlando. For more information: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

ACLS Course (Pediatric), August 22-24, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Emergency Management of Facial, Hand and Soft Tissue Injuries, August 24-28, Ameilia Island Plantation, Amelia Island. Contact: Ira M. Dushoff, M.D., 580 West 8th Street, Jacksonville 32209, (904) 355-0561.

A Stitch in Time, August 24-28, Amelia Island Plantation Convention Center, Part I, Amelia Island. For more information: Ira M. Dushoff, M.D., 580 W. 8th Street, Jacksonville 32209, (904) 355-0561.

SEPTEMBER

Doppler Echocardiograph Seminar, September 11-13, Innisbrook Resort, Tarpon Springs. Contact: Ann Connelly, R.N., 300 South Hawthorne Road, Winston-Salem, NC 27103.

Aviation Medical Seminar — For Aviation Medical Examiners, September 18-21, Doral Hotel, Miami. Contact: James L. Harris, M.Ed., P.O. Box 25082, Oklahoma City, OK 73125, (405) 686-4881.

Pediatrics for the Practitioner, Sept. 19, Bay Harbor Inn, Tampa. Contact: Herbert H. Pomerance, M.D., USF Dept. of Pediatrics, 12901 N. 30th Street, Box 15CE, Tampa 33612, (813) 974-4214.

Pediatrics for the Practicing Physician, Sept. 19, 1986, Bay Harbour Inn, Tampa. Contact: H.H. Pomerance, M.D., (813) 974-4214.

Pediatrics for the Practitioner: Update in Hematology and Oncology, Sept. 19, Bay Harbour Inn, Tampa. Contact: H.H. Pomerance, M.D., USF Dept. of Pediatrics, 12901 N. 30th Street, Box 15CE, Tampa 33612, (813) 974-4214.

OCTOBER

Cardio Respiratory Disease, October 1-4, Marriott's Orlando World Center, Orlando. Contact: Patti Devlin — CME Coordinator, Orlando Regional Medical Center, 1414 S. Kuhl Avenue, Orlando 32806-2093, (305) 841-5144.

Fourth Annual Advanced Neuroradiology Seminar, October 9-11, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Fifth Annual Medical Laboratory Immunology Symposium, October 19-22, Holiday Inn Surfside, Clearwater. Contact: Herman Friedman, Ph.D., (813) 974-3281.

Arrhythmias: Interpretation, Diagnosis and Management, Oct. 24-25, Orlando Hyatt Hotel, Orlando. Contact: Deborah Wilderson, 5808 S. Rapp Street, #202, Littleton, CO 80120 (303) 798-9682.

NOVEMBER

Neonatal and Pediatric Respiratory Disease Conference, November 6-9, Holiday Inn Sufside, Clearwater Beach. Contact: R.L. Siegel, M.D., USF College of Medicine, 12901, N. 30th Street, Tampa 33612, (813) 972-3131.

DECEMBER

Refinements in Gastroenterologic Diagnosis, December 3-5, 1986, Contemporary Hotel, Lake Buena Vista. Contact: H. Worth Boyce Jr., M.D., USF Medical Center, Box 19, 12901 N. 30th Street, Tampa 33612, (813) 974-2034.

Workshop on Clinical Hypnosis, December 4-7, 1986, Tampa Hilton, Tampa. Contact: Alexander A. Levitan, M.D., 2051 Long Lake Road, New Brighton, Minnesota 55112, (612) 786-1620.

Vascular and Pulmonary Diseases, December 5-6, 1986, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson, 5808 S. Rapp Street, -202, Littleton, CO 80120, (303) 798-9682.

Magnetic Resonance Imaging, December 8-12, 1986, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

International Conference on Hypertension in the Elderly, December 12-16, Wyndham Hotel Sea World, Orlando. Contact: Bruce Robinson, M.D., (813) 974-2460.

JANUARY

Oculoplastic Symposium 1987, January 24-31, University of Miami, Miami. For more information, contact: University of Miami, Department of Ophthalmology, P.O. Box 016960, Miami, 33101, (305) 964-0707.

HOW DOES YOUR CHILD MEASURE UP



Two-thirds of our children can't pass a basic physical fitness test. Many show early signs of heart and circulatory problems.

Why? Most children do not get proper exercise to stay in shape.

The Presidential Physical Fitness Award Program offers a way of getting fit that's effective and FUN.

SUPPORT YOUR CHILD

...when it comes to physical fitness. Find out if your child's school has a sound physical education program. Write:

FITNESS
Dept. 35
Washington, D.C.
20001

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name: _____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

PRIMARY CARE CENTERS IN FLORIDA, NEW YORK, NEW JERSEY: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full time basis. Positions available in Central and South Florida coastal communities, central and northern New Jersey, and Long Island, New York area. Guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 930 South Harbor City Blvd., Suite 307, Melbourne, FL 32901.

DIAGNOSTIC RADIOLOGIST, Board Certified needed to join rapidly expanding hospital based solo-practice. Must have angiography/special procedures training/experience. Personable, willing to practice hands-on radiology. Large hospital located on the west coast of Florida, well equipped, MRI Pending. Box C-1329, P.O. Box 2411, Jacksonville, Fl. 32203.

FAMILY PHYSICIAN: Board eligible; for West Palm Beach practice. Florida license necessary. Opportunity for future partnership. 305-967-0234 Send C.V. to C-1338, P.O. Box 2411, Jacksonville, FL 32033

A WEEK, A YEAR, A CAREER — Practice opportunities in Jacksonville, Miami, Orlando, Daytona Beach, Tampa. Options for permanent and/or locum tenens placements in all specialties. Trial associations with established practices in a variety of clinical settings. Call Suzanne J. Anderson at 800-833-3465 or write: Medstaff, Inc., P.O. Box 15538, Durham, NC 27704.

FAMILY PRACTICE PHYSICIANS: Opportunity for two Board Certified or Board Eligible Physicians with Florida license to join a Community Medical Practice under guidance of a recognized M.D. leader. Currently beikng developed, ideally located, the medical complex also will include laboratory, radiology and rehabilitation, in initial phases. Location on Florida's Gulf Coast in Sarasota. An attractive benefit package includes base, participation, malpractice insurance, continuing educational support, vacation, etc. Physicians interested in this professional growth potential should forward covering letter and curriculum vitae to Joseph Doney, D.H.A., P.O. Box 48926, Sarasota, FL 33578.

FAMILY PRACTICE — Orlando: Career opportunity BC/BE — Office, hospital practice in new office opening Nov. '86. Attractive financial package, guarantee, production bonuses, full insurance, share of corporation without investment. Send CV to Troy Overstreet, 120 Sunnytown Road, Casselberry, Fl. 32707, 305-339-7171.

CARDIOLOGIST: Established young BC cardiologist needs associate-partnership. BE/BC and U.S. trained. Non-invasivewith invasive potential. Miami, FL. Respond with CV to C-1339, P.O. Box 2411, Jacksonville, FL 32203.

GENERAL INTEREST — For great opportunity in Jacksonville, Fl. Start your own private independent practice, with no start-up costs. A great opportunity in a multi-specialty environment.

GEORGIA: Directors and full-time and part-time Emergency Physicians needed for 155-bed and 157-bed hospitals in southern Georgia. 12,000-16,000 annual ED visits. Professional liability insurance procured. For further info, contact: Coastal Emergency Services, Inc., P.O. Box 925, Augusta, GA 30903; collect (404) 724-3368.

EMERGENCY MEDICINE opportunities available for experienced Emergency Physicians in northeast Florida. Competitive compensation, growth opportunities and complete professional liability insurance package. Contact: Kathy Valli, Coastal Emergency Services, Inc., 2200 West Commercial Blvd., Ste. 203, Fort Lauderdale, FL 33309 (800) 328-1038, (800) 432-3093 in FL.

TAMPA — Excellent opportunity to become the primary physician of a well established growth oriented Family Practice in the fastest growing city in the South. Practice benefits include association with a specialty group, computerized management system, X-ray, laboratory, spirometry, modern offices in pleasant surroundings. We are seeking a Board Certified or Board Eligible Family Practitioner, highly motivated and dedicated to the delivery of quality health care. Excellent base salary plus strong incentives based on revenues. We will provide assistance with interview and relocation expense. If you would like to be an important part of our growing team, send your CV to John Q. Stauffer, M.D., 2919 Swann Avenue, Suite 205, Tampa, FL 33609, or call 813-879-3971.

FAMILY, GENERAL OR INTERNAL Medicine Practitioner needed immediately for a well established, successful Family/General Practice in North Central Florida. Office has laboratory, X-ray, EKG facilities. Board Certified or eligible preferred but not necessary. Send CV to C-1307, P.O. Box 2411, Jacksonville, FL 32203.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

N.W. FLORIDA, OB-GYN, BC/BE to join an expanding busy solo practice in the FL Panhandle on the Mexican Gulf Coast's most beautiful beaches. Metropolitan area of 280,000. Salary and benefit package leading to partnership. Please reply with CV to Linda H. Ferguson, 5120 Bayou Blvd., Suite 11, Pensacola, FL 32503.

THE MEDICAL CENTER AT OCEAN REEF, INC., North Key Largo, FL, a member operated, tax exempt facility, is seeking a second, board certified family practice or internist physician for annual employment. The Center provides 24 hour emergency, including basic life support ambulance and continuing care to its members and others in the North Key Largo area year round. Compensation includes salary, pension, health and malpractice insurance, residence and eight weeks paid vacation annually. Address inquiries to Barbara Soto, Administrator, Medical Center at Ocean Reef, Inc., 30 Ocean Reef Drive, North Key Largo, Florida 33037 or phone (305) 367-2294.

MEDICAL EXECUTIVE DIRECTOR wanted by Pinellas County Health Department. Responsible for administration of clinical programs. Training and experience in management and Florida medical license are required. Annual salary: $57,000. Contact R.A. Levinson, M.D., P.O. Box 13549, St. Petersburg, FL 33733. EEO/AA.

FT. PIERCE, FLORIDA — Full time emergency department position available in a 240 bed hospital with an annual ED volume of 24,000. Candidate must be board prepared in emergency medicine. The hospital is centrally located between Disney World and Miami on Florida's Treasure Coast. Excellent compensation and malpractice insurance provided. Please send CV to Cheree Richards, EMSA, 8200 W. Sunrise Blvd., Plantation, FL 33322, or call (305 472-6922.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

TWO BOARD CERTIFIED SURGEONS — one general and one general vascular with or without non-cardiac throacic — wanted to join staff at the VA Medical Center Lake City, FL. Potential academic appointment at University of Florida. Affiliation in surgery with the University of Florida. Competitive salary plus incentive pay commensurate with qualifications. Liberal benefits plus malpractice insurance and retirement program. The North Florida area offers an excellent climate year round,l extensive outdoor recreational activities, lower than average cost of living, fine schools and nearby university, local community college, uncongested commuting to and from the Medical Center. Contact John H. Beggs, M.D., Chief of Staff, VA Medical Center, Lake City, FL 32055, (904) 755-3016, Ext. 2011. An Equal Opportunity Employer.

OB-GYN NEEDED — productive and rewarding practice located in beautiful lake/river area of Florida needs third Ob-Gyn for potential partnership. Please respond to C-1335, P.O. Box 2411, Jacksonville, FL 32203.

ORTHOPEDIC SURGEON wanted for growing Central Florida practice. Excellent benefits. Send C.V. to 317 N. Mangoustine Ave., Sanford, FL 32771.

SENIOR PHYSICIAN, Seminole County Public Health Unit. Current Florida License, minimum salary: $44,578. Respond: Ana Palenzuela, 240 W. Airport Blvd., Sanford, FL 32771, (305) 322-2724, ext. 235.

ST. PETERSBURG, FL: Emergency Department physician. 42 hours per week. Nights and week-ends. Excellent compensation. Send C.V. to: Diane, P.O. Box 12077, St. Petersburg, FL 33733.

PEDIATRICIAN — multi-specialty group in East Central Mississippi with three other pediatricians. Excellent fully equipped hospital, JCAH accredited. BC/BE. Initial salary with later productivity based income. Partnership in two years. No HMO/PPO affiliations. Send CV to Kenneth J. Reid Jr., M.D., Rush Medical Group, P.A., 1314 19th Avenue, Meridian, MS 39301.

E.R. FULL TIME OR part-time: East Coast — Community hospital, 12000 visits/year, excellent opportunity for board prepared/certified, E.M. or primary care specialty with E.R. experience. Excellent salary, small group and easy to arrange schedule, needed immediately. Call 672-4791 or 677-9183.

GROWING PRIMARY CARE Center on east coast central Florida needs a full time physician. Send CV to P.O. Box 524, Rockledge, FL 32955, or call Mrs. Moore, (305) 639-1601.

WANTED: A GENERAL SURGEON and urologist with in depth training in surgical urology and office urology to associate with D.O. on the west coast of Florida in active urological and general surgical practice. Please mail curriculum vitae with recent photograph to B. Warren Smith, D.O., 10333 Seminole Blvd., Largo, FL 33540.

OPHTHALMOLOGIST: wanted retired non-surgical ophthalmologist with Florida license to join large multi-specialty group practice. Send CV to C-1337, P.O. Box 2411, Jacksonville, FL 32203.

CHILD AND ADOLESCENT PSYCHIATRIST. 80-100k salary. Send C.V. to: 8130 Baymeadows Circle, W., Suite 306, Jacksonville, FL 32216.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

OPENING FOR RADIOLOGIST: Diagnostic radiologist with interest and experience in mammography and ultrasound needed to staff new radiology office. Monday-Friday, 8-5. Florida License required. Salary negotiable. Contact K. Jay Adcook, M.D., 515 S. Orange Ave., Orlando, FL 32801, (305) 425-1518.

Situations Wanted

AM INTERESTED in buying internal medicine/family practice in Broward or Palm Beach County. Can assume immediately. Contact: R. Dandiya, M.D., 33 William Street No. 3L, Mt. Vernon, N.Y. 10552, (914)668-5219.

LOCUM-TENENS: RADIOLOGIST, Board Certified, un;iversity trained with academic background, age 47, experienced in most modalities, will consider office and/or hospital-based practice. Please write C-1311, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST — Board Eligible, seeks position in Florida, either in hospital or with group offering opportunity for the development of procedural skills. Available the end of September, 1986. C-1343, P.O. Box 2411, Jacksonville, FL 32203.

42-YEAR-OLD, male internist-nephrologist, nine years of private practice experience, wishes to buy established internal medicine, or family practice, or to associate with a solo practitioner, or group. Other opportunities such as HMOs would be considered. Area of preference would be Broward, Palm Beach, including West Palm Beach, and Orange Counties. Other areas would also be considered. Please respond to Richard Eanni, M.D., 19 Fernandez Ave., New Windsor, New York 12550.

BOARD CERTIFIED (Family Medicine) Florida license seeks 40 hour a week position in family clinics, public health or nursing homes, also Locum Tenens or emergency room. Call or write to: Celedonio C. Barrameda, M.D., 312 N.E. Ardsley Dr., Port St. Lucie, Fl. 33452, 1-305-878-6608 preferably evenings.

RADIOLOGIST, Board certified, 35, wishes to relocate in Florida in fall of 1986, prefer private practice. Proficient in diagnostic imaging (CT/US) and angiography, some nuclear medicine. Reply to: R.W. Stone, M.D., 5597 Seminary Road, Falls Church, VA 22041.

Practices Available

RETIREMENT MINDED OB-GYN in north Florida looking for partner in practice grossing 400,000 t. Partnership immediately with transfer of practice in two years. C-1316, P.O. Box 2411, Jacksonville, FL 32203.

FLORIDA WEST COAST: Splendidly located, freestanding clinic for family practice or walk-in. Laboratory and x-ray. Rapidly expanding community. Nearby accredited hospital. Annual gross over 400,000.00. C-1321, P.O. Box 2411, Jacksonville, FL 32203.

MEDICAL PRACTICE SALES. Listed are a few available practices: Allergy — large Philadelphia practice; FP & Int. Med. — two Philadelphia practices; Internal Medicine — Arizona, Bethesda, Maryland, large practice in Western Pennsylvania; Orthopedic Surgery — Western Pennsylvania; Pediatrics — Colorado, Eastern Pennsylvania and Southern New Jersey; Surgery — New Jersey. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice, contact our brokerage division at Health Care Personnel Consulting, 403 GSB Building, Bala Cynwyd, Pa. 19004, 215-667-8630.

JACKSONVILLE — Family practice for sale located in the Arlington area. Physician retiring. Will sell Medical Office on terms — practice and equipment could be included. Once in a lifetime opportunity. For further information write or call: Broach/Shumer Realty Group, Inc., 4490 Southside Blvd., Jacksonville, 32216 (904) 642-6200.

GYNECOLOGY, solo practice, for sale, 8 yrs. old. Central Florida, medium size town, opportunity for OB if wanted. $30,000 firm, instruments included. C-1341, P.O. Box 2411, Jacksonville, FL 32203.

FT. LAUDERDALE Radiology office building and equipment for sale. Siemens, Kodak and Technicare. d(305) 771-9500 or (305) 942-2946.

FOR LEASE: Fully equipped medical facility. Complete lab, x-ray, orthopedic and surgery departments. Suitable for solo or group practice. Will consider lease with option to buy. Contact J. Davis, P.O. Box 25337, Sarasota, FL 34277.

NAPLES, FL, Urologist retiring. Desires to sell desirable office building and equipment. Will give good terms to qualified urologist. Call 813-262-1521 or 813-262-3996.

UNOPPOSED GYNECOLOGICAL Practice for sale. Downtown Miami. Grossing $300,000.00 plus yearly. Efficient staff speaking English, Spanish and Creole. Will stay on. Terms negotiable.

Real Estate

SPRING HILL, FL - 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease - owner will finance. (904) 596-4162 weekdays.

PRIME LOCATION for professional office rental of 1125 sq. ft. for $985.00 per month in Sarasota, FL. For further please phone 813-955-7361.

RETIRING BOARD CERTIFIED OB-GYN selling or leasing completely equipped office. Capacity for 2 or more Ob-Gyns. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone 305-667-3677.

VERO BEACH TIMESHARE: Driftwood Vacation Villas, on the beach, pool, kitchen. Sleeps four. Weeks 3 & 50. $7,000 per week. P.O. Box 1465, Summit, NJ 07901, 201-277-6798.

HAWAII/MSUI TIMESHARE: April 4-18 (Fixed date). On east coast beach, in Kihei. Pool, two bath, kitchen. Sleeps 4. $16,000 Negot. P.O. Box 1465, Summit, NJ 07901. (201) 277-6798.

INVESTMENT — Home and Grove. Lovely 2500 sq. ft. Riverview house with prime 7 acre Citrus Grove. 300 ft. on inland waterway. Located on Merritt Island, Near Kennedy space center. Good terms $435,000, may trade owner (305) 452-6450.

HANDSOME SECOND INCOME: Franchise starting in Florida to physicians and dentist only; do not miss this opportunity call Bob Richardson (305) 977-9322.

CAYMAN ISLANDS -- modern 2 bedroom beach house on Cayman Brac. Superb snorkelling and scuba. Quiet out-island setting. Rental $350.00 per week. Dr. R. Lament, 2187 West 4th Avenue, Vancouver B.C. Canada (604) 733-5722.

SUB-LEASE: Medical/Surgical Office, Ft. Lauderdale, FL. 1000 Sq. Ft. — Good Location — Partly equipped office — Consultation Room — 2 Exam Rooms, Waiting Room — Laboratory (305) 764-4442.

PYMS REAL ESTATE CO., Realtors. 9308 South Dixie Highway, Miami, FL 33156 (305) 666-7967 (PYMS). 6,000 Sq. ft, two-story medical office building. Located on 4-laned westward drive between the U.S. Post Office, City Hall and Police Station, the heart of Miami Springs business district, Dade County. Owner is running an Obstetrics and Gynecology practice (for over 25 years) and will vacate or lease-back part. Owner is motivated and will consider terms. Call for additional information or assistnace: Ronald Silberman, Broker-Salesman (305) 3878-1663 evenings.

BEAUTIFUL WALK-IN Medical Center in beautiful Winter Haven, FL, loaded, excellent location in a cute shopping plaza. Terms cash. Call (813) 299-9000. Dr. Mangal.

TWENTY-SIX ACRES of beautiful mountain land, includes four streams, level farmland with bvarn, Robbinsville, N.C., near resorts. Ideal for development or dwelling. $40,000 (904) 733-1215 or (214) 234-6040.

Services

FINANCIAL SHELTERS IN Switzerland. Legal, secure, strictly confidential. For Information write: Assurex, S.A., P.O. Box 209-R, Volkmarstrasse 10, 8033, Zurich, Switzerland.

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, promptservice. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

LONG TERM FINANCING for starting or puchasing practices, diagnostic centers, equipment, office condos, buildings. $25,000 to $1,000,000. Western Financial, 1380 Miami Gardens Drive, N. Miami, Florida 33179. (305) 949-5900.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WHITEWING DOVE HUNTING: Fastest Wing Shooting in the world! Also, excellent Bass Fishing, Quail and Duck hunting. Lago Vista Lodge on Lake Guerrero, Mexico. Complete facilities with swimming pool and guides. No hassles. Fly into Harlingen, McAllen, or Brownsville, Texas. We handle the rest. Any size group. Make reservations early; dove hunting starts mid August through October. Paloma Guide Service 512-991-4197 nights.

WE BUY, SELL, LEASE SERVICE new and preowned medical instrumentation: Holter-Stress-Ultrasound-EKG Lab etc. Contact New Life Systems, Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065; 305-972-4600.

WEEKEND INTENSIVE THERAPY for individual, marital, family problems. Sexual dysfunction. Certified Sex Therapist, AASECT. Licensed Marriage and Family Therapist. Contact: Jane Woody, Ph.D., Family Psychology Clinic, Suite 15, 1919 Courtney, Ft. Myers, FL 33901; telephone (813) 939-0607.

ATTORNEY FOR PHYSICIANS for business, professional regulation, records, malpractice, and standard of care issues. Vitae: Doctor of Science, Health Services Administration (University of Pittsburgh); Juris Doctor, Law (Creighton University); 20 years health-care experience; Professor; publications. Licensed to practice law in Florida, Michigan, and Nebraska. Contact: Robert Woody, Attorney at Law, Suite 205, 1950 Courtney, Fort Myers, FL 33901; telephone (813) 939-4321.

Equipment

CLINITRON BED — individual selling used clinitron bed. $18,000, 904-241-8344.

Meetings

WEEKLY SEMINARS — Medical/Legal and Financial Management. Aspen, Disney World, Hollywood, FL, Nassau, Park City, Steamboat Springs, Sun Valley. Fee $185. For information: Current Concept Seminars 3301 Johnson St., Hollywood, FL 33021 (305) 966-1009. For reservations: (800) 428-6069. Meets the new risk management CME requirement.

Victoria Ann-Lewis moves so gracefully on stage the audience doesn't even know she has polio.



VICTORIA ANN-LEWIS/ARTIST IN RESIDENCE AT THE MARK TAPER FORUM IN LOS ANGELES.

Believe in them. Break the barriers.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, WASHINGTON D.C. 20210

PRODUCED BY THE SCHOOL OF VISUAL ARTS PRESS LTD

ATTENTION PHYSICIANS
FOR SALE
Medical Clinic and Physicians Practice
Modern 3600 sp. ft. Building with Parking Lot

- Waiting Room
- Reception Area and Business Office
- Three Doctors Offices
- Six Exam Rooms
- X-Ray Room
- Lab
- Minor Surgery and Trauma Room
- Employees Lounge
- Three Lavoratories
- Security System
- Full Equipped Including X-Ray and All Exam Rooms, Lab, Surgery Room, Office Furnishings
- Excellent Patient Base — Very Low Accounts Receivables

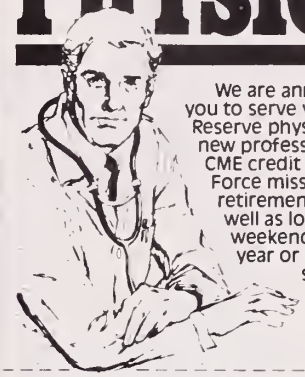
Ideal for Two or Three Doctors

Located on the "Treasure Coast"

A Great Place to Live and Work

Call Donald J. Colacino
Realtor
(305) 286-5600

PHYSICIANS



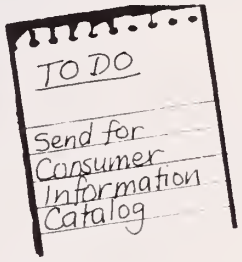
We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HQ 10 AF/RSH
Bergstrom AFB, TX 78743-6002
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Prior Service? Yes ___ No ___
Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE

Put Our List On Your List



Our list can help you do the other things you have on your list. Such as fix the car . . . check on social security . . . start the diet . . . find out about the loan.

Our list is the Consumer Information Catalog. And it's free. So are many of the more than 200 government booklets in the Catalog. Booklets on employment, health, safety, nutrition, housing, government programs, and lots of ways you can save money.

The Consumer Information Center of the U.S. General Services Administration publishes the Catalog quarterly to bring you the most up-to-date word.

So to shorten your list, send for the free Consumer Information Catalog. It's the thing to do.

Just send us a postcard or letter with your name and address. Write:

Consumer Information Center
Dept. PA
Pueblo, Colorado 81009

GSA U.S. General Services Administration



A Kiss Can Save A Life

When you kiss your child, you give and receive love. But your kiss could also be a test for cystic fibrosis, an inherited respiratory and digestive disease. An excessively salty taste to the skin is one symptom of cystic fibrosis. Call your doctor or local Cystic Fibrosis Foundation Chapter for more information. Early diagnosis and treatment can be the key to a better quality of life for CF children.

Meantime, kiss your baby. It's a good idea, anyway.

WHAT GOES UP, BETTER COME DOWN.



Many of the 60 million Americans who have high blood pressure don't know it. You could be one of them. So call the Red Cross and have your blood pressure checked. Because high blood pressure means a high risk of heart attack or stroke. And, unfortunately, the law of gravity doesn't affect it.

American Red Cross

Ad Council

ADVERTISERS

American Medical International
Service 498b

Air Force Reserves
Recruitment 571

Army/Army Reserves
Recruitment 501

BellSouth Mobility
Service 499

Brown Pharmaceutical
Android 512
Lipo-Nicin 539

Curtis 1000 Information Systems
Computers 540b

Donald J. Colacino
Real Estate 571

Eli Lilly & Company
Keflex 558a

FMA Sponsored Insurance Plans
Service 500

Florida Physicians' Insurance Company
Service 498

GTE Telenet
Service 504

Health Care Assistance Corporation
Service 529

Info Systems
Computers 512

Janssen Pharmaceutica
Vermox 511

Knoll Pharmaceutical Company
Isoptin 558b
Vecodin 540a

Marion Laboratories, Inc.
Cardizem 530a

Medical Expo '86
Meeting 511

Nutrition Medical Centers
Service 530

Prudential Bache Securities
Service 540

Roche Products, Inc.
Dalmane 575

Southwest Florida Heart Institute
Meeting 516

University of Miami
Meeting 539

Upjohn Company
Motrin 498a

Willingway Hospital
Service 530

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D., Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

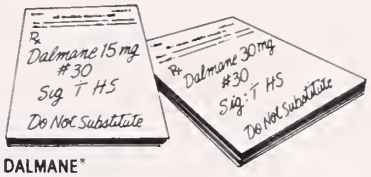
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
brand of
flurazepam HCl/Roche Ⓒ
sleep that satisfies

15-mg/30-mg
capsules



References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR, *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
brand of
flurazepam HCl/Roche Ⓒ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.* excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see preceding page for summary of product information.

DALMANE®
brand of
flurazepam HCl/Roche ℞
sleep that satisfies



COLLEGE 000 28
COLL. OF PHYS. OF PHILADELPHIA
LIBRARY
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

Copyright © 1986 by Roche Products Inc. All rights reserved.

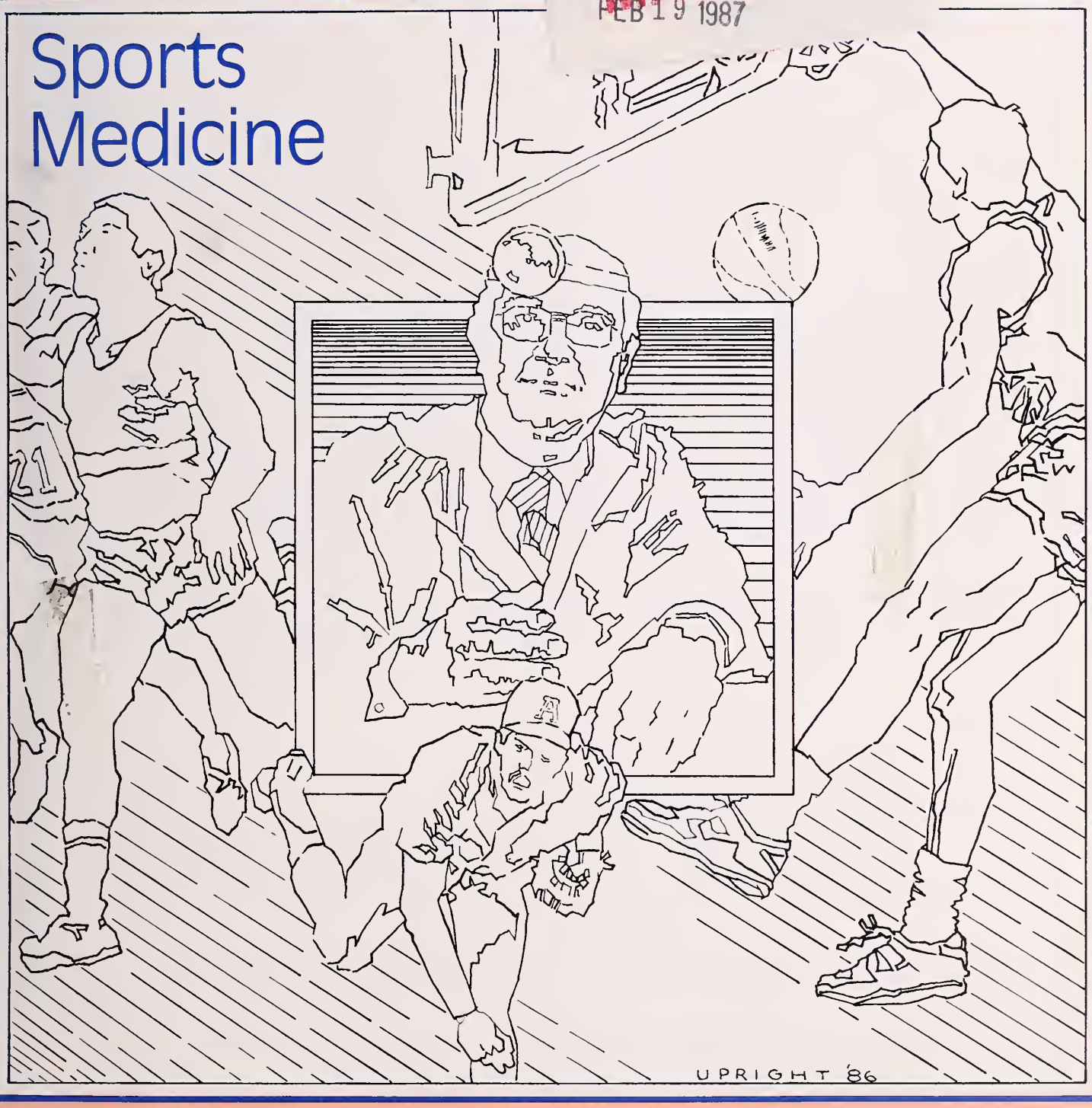
ROCHE®

STACKS

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. AUGUST 1986, Vol. 73, No. 8

COLLEGE OF PHYSICIANS
M.D.S.
FEB 19 1987

Sports Medicine



Select Quality!

The chart on this page can be used to compare the advantages of insuring with Florida Physicians Insurance Company. All medical professional liability insurance coverage is NOT the same!

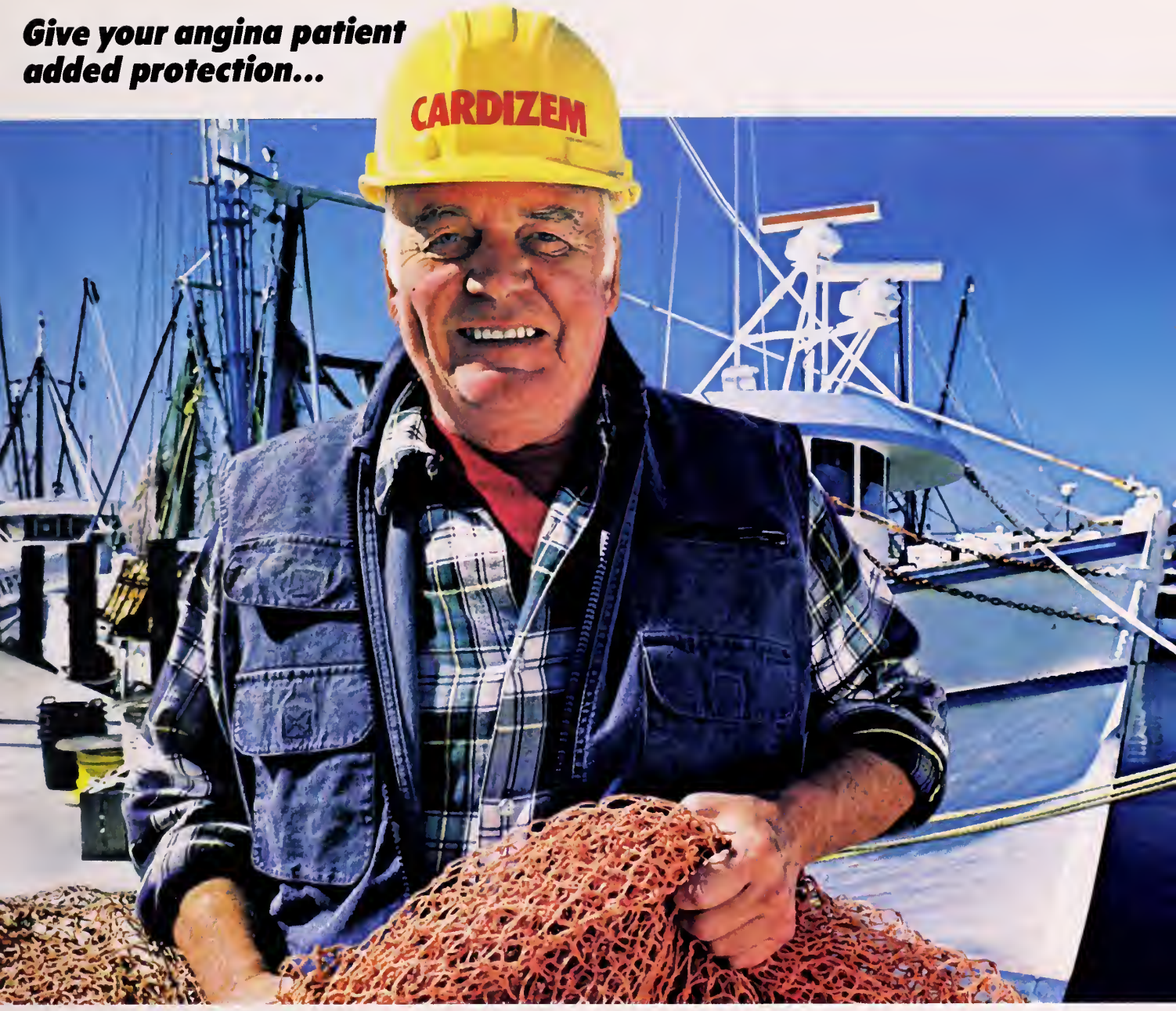
QUESTION	FPIC	PPTF	ST. PAUL
Are your carrier's premiums non-assessable ?	YES	NO	YES
Is your carrier medical association sponsored ?	YES	NO	NO
Is your carrier Florida owned and operated ?	YES	YES	NO
Is the majority of your carrier's Board of Directors made up of physician's ?	YES	YES	NO

For more information call Ron Gladman:

FPIC FLORIDA PHYSICIANS INSURANCE COMPANY

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

Give your angina patient added protection...



CARDIZEM®: FEWER SIDE EFFECTS

diltiazem HCl/Marion

- ***The lowest incidence of side effects among the calcium channel blockers*** [1-6]
- ***A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD*** [4,7]
- ***Proven efficacy when used alone in angina*** [3]
- ***Compatible with other antianginals*** [8,9]*

See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.



CARDIZEM® FEWER SIDE EFFECTS IN ANTIANGINAL THERAPY

diltiazem HCl/Marion

60 mg tid or qid

Brief Summary
Professional Use Information
CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets
CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).
WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction 24% ± 6%) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using the drug in such patients.*
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 11/85*
See complete Professional Use Information before prescribing.

References: ***1.*** *Frishman WH, Charlap S, Goldberger J, et al: Comparison of diltiazem and nifedipine for both angina pectoris and systemic hypertension. Am J Cardiol 1985;56:41H-46H.* ***2.*** *Weiner DA, McCabe CH, Cutler SS, et al: The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. Clin Cardiol 1985;7:648-653.* ***3.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983;106(6):1341-1347.* ***4.*** *Cahn PF, Brounwald E: Chronic ischemic heart disease, in Brounwald E (ed): Heart Disease. A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *McCall D, Wolsh RA, Frahlich ED, et al: Calcium entry blocking drugs: Mechanisms of action, experimental studies and clinical uses. Curr Probl Cardiol 1985;10(8):6-80.* ***6.*** *Chaffman M, Brogden RN: Diltiazem. A review of its pharmacological properties and therapeutic efficacy. Drugs 1985;29:387-454.* ***7.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50 (Sept):94-116.* ***8.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***9.*** *Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris. A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.*

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137

1289K6

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

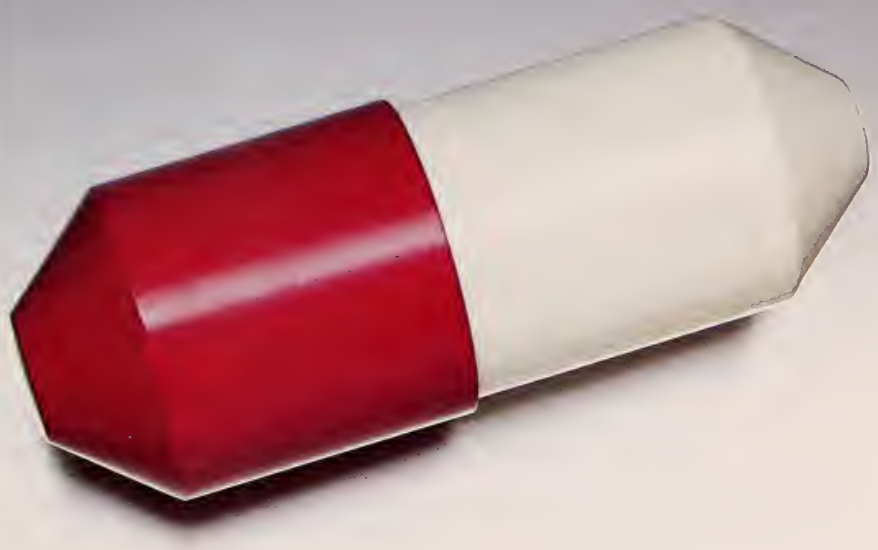
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L42

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 20 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.



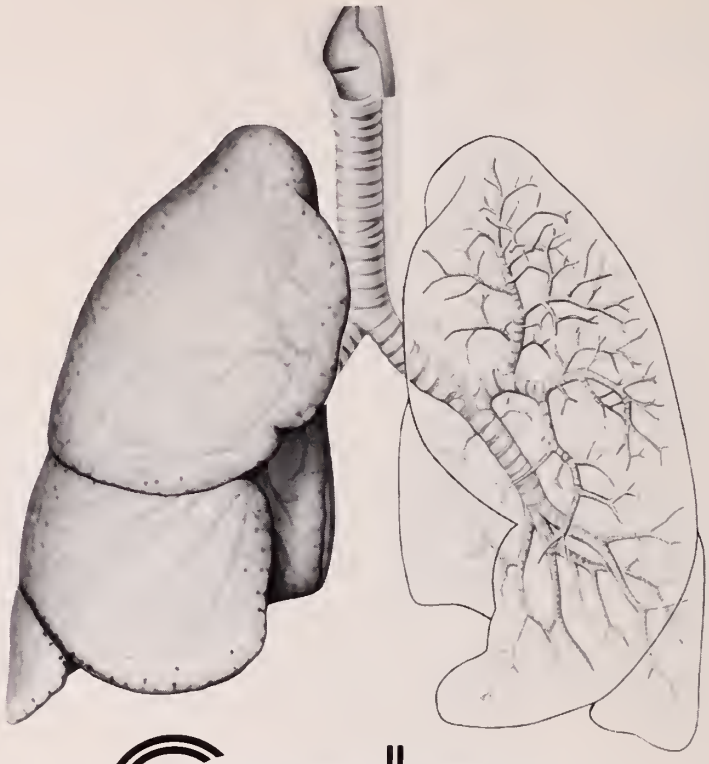
a product of

SK&F CO.

Carolina, P.R. 00630

©SK&F Co., 1983

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, H influenzae, Streptococcus pneumoniae, Streptococcus pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

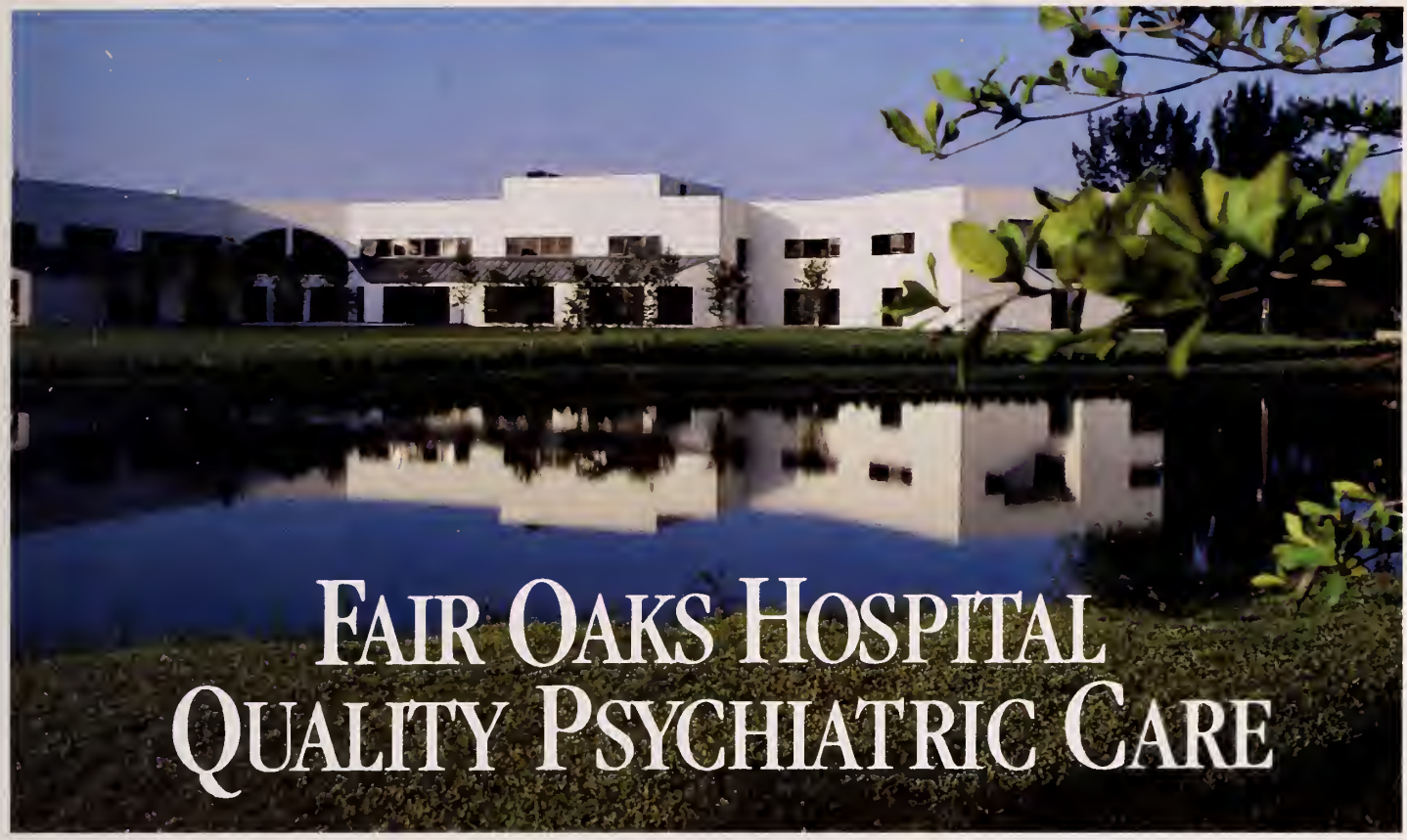
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

© 1986, ELI LILLY AND COMPANY [060485LR]

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

600332



FAIR OAKS HOSPITAL
QUALITY PSYCHIATRIC CARE

Fair Oaks Hospital at Boca/Delray is a psychiatric facility that values the judgment of the referring physician. Our specialty programs are led by full-time Yale-trained psychiatrists who value and utilize the medical model.

As the referring physician, you have the opportunity to collaborate closely with our staff physicians during all phases of evaluation and treatment.

A thorough patient evaluation is conducted on the Neuropsychiatric Evaluation Unit before treatment is administered. Thorough medical, neurological and neuroendocrine testing is performed, in addition to psychological and family assessments. Individualized treatment plans are carried out by our multidisciplinary treatment teams on our Adult Psychiatric Unit, Addiction Unit and Adolescent Hospital.

The Addiction program specializes in cocaine abuse and has pioneered in new treatments for the cocaine abuser.



Fair Oaks also has a unique reference source . . . cocaine addicts themselves.



Serving as the local sponsor for the **1-800-COCAINE** National Helpline for Florida callers, we have a direct link to drug users. Fair Oaks is able to apply Helpline information in the development of treatment and research programs.

The Adolescent Hospital is under the direction of a full-time board certified child and adolescent psychiatrist and includes a full-time school program. Specialized tracks exist for adolescent patients with psychiatric and substance abuse problems. Admissions counselors are available 24 hours a day to discuss all details concerning the hospital.

For more information call or write:

Admissions Coordinator
Fair Oaks Hospital at Boca/Delray
5440 Linton Boulevard — 305/495-3737
Delray Beach, FL 33445 — 305/495-1000

FAIR OAKS
HOSPITAL
AT BOCA/DELRAY

PHYSICIANS, WE SCHEDULE OUR TIME TO FIT YOUR TIME.

We're very flexible in the Army Reserve about time. We take into account your practice, your time and availability.

We're not flexible about the quality of medicine. We demand much of ourselves and of every member of our medical team.

If you'd like to learn more about the medical opportunities in a nearby Army Reserve unit, call your Army Medical Personnel Counselor:



3101 MAGUIRE BLVD.
ESSEX BLD., SUITE 166
ORLANDO, FL 32803
CALL COLLECT: (305) 896-0780

ARMY RESERVE. BE ALL YOU CAN BE.

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

THE MEDICAL SYSTEM INCLUDES:
- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

ADVANTAGES
- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

INTERESTED?
For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

The ISI Software Question

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5mg Buccal/10mg Oral/25mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10mg





THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

AUGUST 1986, Vol. 73, No. 8

CONTENTS

SCIENTIFIC ARTICLES

John W. McDonald, M.D.	**599**	Sports medicine: a growing specialty
Marcos T. Doxanas, M.D.	**600**	Ocular injuries in sports
John T. Devlin, M.D.	**602**	Effects of exercise in diabetes mellitus
G. Rodney Meeks, M.D.	**604**	The benefits and reproductive risks of exercise to women
Donald L. Ames, M.D.	**607**	Overuse syndrome
Mutaz B. Habal, M.D.	**609**	Athletic injuries caused by the new sport of windsurfing and a proposed set of preventive measures

SPECIAL ARTICLES

Jacqueline M. Moore, R.N., M.S.N.	**615**	Prison health care: problems and alternatives in delivery of health care to the incarcerated — Part II
H. Frank Farmer, M.D., Ph.D.	**621**	On the brink of disaster — the divergence of American culture and American medicine

COVER

This month's cover of *The Journal* is a drawing by James B. Upright, a Jacksonville artist. It relates to the Scientific Articles on Sports Medicine.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.* [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc., are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Florida Medical Association, Inc.

DEPARTMENTS

585 President's Page
Transitions in leadership: unity in purpose
Luis M. Perez, M.D.

587 Editorials
Medicare in troubled waters
R.G. Lacsamana, M.D.

589 The drug problem: tilting with windmills
R.G. Lacsamana, M.D.

593 Letters & Viewpoints

627 Medical Economics
Physician reimbursement for Medicare beneficiaries (II): implications of regional and national fee schedules
Jacques R. Caldwell, M.D.

631 Notes & News

632 112th Annual Meeting

636 Dean's Message

637 Encores!

643 Book Reviews
Physiology of exercise and sport
James B. Perry, M.D.

645 FMA Auxiliary
AMA Auxiliary convention creates motivation
Mrs. Rex (Betty) Orr

648 Meetings

652 Classified Advertising

658 Index to Advertisers

658 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Karl Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.



Academy of Neuro-Muscular Thermography

Second Annual Meeting

Friday, Saturday, Sunday: September 26, 27, 28, 1986
Wyndham Hotel, Orlando, Florida

Research Papers • Disability Evaluation Roundtable • Legal Perspectives

Meeting Registration Fee (includes Cocktail Party and two lunches):
$185 ANMT Technologist Member
$385 ANMT Physician Member
$395 Non-Member Physician
$425 All Others

Continuing Medical Education Credits:
Approved for 18 hours AMA Category I CME Credits from the University of Florida School of Medicine-JHBP.

Special Room Rate for Meeting Attendees:
$90/night. Contact the Wyndham Hotel directly for room reservations and information, toll-free outside of Florida at 1-800-331-6600.

Meeting Registration/Information:
Barbara
Academy of Neuro-Muscular Thermography
5400 Balboa Blvd., Suite 141
Encino, California 91316 • (818) 986-6693

Meeting Reservation Form

Send this form with meeting fees to:

Academy of
Neuro-Muscular Thermography

5400 Balboa Blvd., Suite 141
Encino, CA 91316

Name_____

Address_____

City_____

State_____ Zip_____

Transitions in leadership: unity in purpose



One month from now I will be passing the gavel to James Perry, M.D., your President-Elect. We have worked this past year together in complete harmony with common goals and absolute dedication to attain our aims. We know that the work ahead is still arduous because the number of issues facing medicine involving the proper care of the people of Florida are very complex.

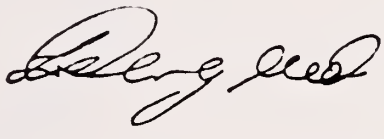
All the physicians in Florida should be prepared to continue the struggle with the liability issue if the insurance companies and the trial bar prevail in the courts. If this should happen, all will have to be redone. Whether they prevail or not, we still have the elections to face. Several of our friends in the legislature may be in jeopardy and some of our enemies are vulnerable. We have to concentrate on these races and support the former and defeat the latter. In this way our position will be enhanced if we have to go back to the legislature. At the same time we have to work creating the initial solutions for the care of the medically indigent and the elderly, a better and more logical organization to trauma centers and the need to ajudicate monies in the budget to all these problems. However, we must keep in mind that these are problems of society in general, not only of doctors and hospitals. These groups are already doing all that is possible within the economical constrictions we all face.

The problems and restrictions that we must deal with that are caused by semi-socialized medicine, DRGs, PROs, and all the new programs in the making will occupy our attention in the years to come. These problems must be handled at their source — the federal government in Washington.

We have to increase our strength in the AMA through increasing our membership. By the sheer number of our delegates we can help to direct the work in the nation's Capitol and at least alter the direction in which we are headed.

There is a tremendous number of intermixing issues that are affecting our profession. Only with dedication, perseverance, and unity in purpose can we solve every one of them.

Let us all continue to work together and not look for the enemy outside, because the worst enemy is us.



WHAT GOES UP, BETTER COME DOWN.



Many of the 60 million Americans who have high blood pressure don't know it. You could be one of them. So call the Red Cross and have your blood pressure checked. Because high blood pressure means a high risk of heart attack or stroke. And, unfortunately, the law of gravity doesn't affect it.

American Red Cross

Ad Council

Medicare in troubled waters

Medicare began in 1965 amidst blaring political fanfare and great expectations that it would revolutionize medical care for the elderly in this country. Born during the heyday of the Great Society when the nation was swept in a sea of social programs, Medicare was awash in controversy from its inception. Medical leaders at the time questioned its fiscal soundness, contending that the program was going to be far more expensive than its sponsors had predicted. And of course they were right. Twenty-one years after its birth, Medicare is mired again in controversy, burdened by lack of money, and threatened by bankruptcy in a few years. Meanwhile, the great promise to elderly Americans has yet to materialize.

Medical care in this country obviously has become quite expensive over the past twenty years, fueled by inflation, high medical technology, increasing demands on the health system, a nightmarish liability crisis, and the burgeoning number of elderly Americans. While nobody at the time could have predicted the magnitude of the soaring costs in medical care, the sponsors of the program should have learned from the example of Great Britain that socialized medicine is no cheap bargain. The first signs that all was not well with Medicare surfaced in the 70s, when the costs of health care took on quantum leaps, reaching critical proportions in the 80s when the overseers of the program started talking about possible bankruptcy in a few years. With increasing pressures on the current administration to cut the budget deficit, the time has now come where more budget cuts will have to be made from Medicare, a prospect that is not going to please anybody, particularly Medicare beneficiaries.

President Reagan and every politician before him have promised elderly Americans that they are not going to tamper with their Medicare benefits. That may be smart political rhetoric, but it is sheer naivete to believe that cost-cutting efforts will not affect Medicare benefits. Programs to contain Medicare costs dating back to the administration of ex-President Richard Nixon have raised more questions and provided fewer answers, spawning the great debate on whether it is feasible to prune millions of dollars from the program and at the same time maintain the high quality of care that Americans have come to expect. While this is not to say that our health care system is extremely efficient and provides no room to cut off any fat, the political wizards making crucial decisions on Medicare must ponder the potential effects of their axe-cutting actions before they come up with more Draconian solutions to Medicare's fiscal problems.

If there is any consensus so far on Medicare reforms enacted from the 70s to the present, it is that most of them have not worked and are stripping the ability of physicians to practice medicine while compromising the quality of care to patients in many instances.

The PSRO law enacted in 1972 is a classic example of a program with good intentions but which had gone haywire because of political shortsightedness and bureaucratic ineptness. Passed by Congress ostensibly to promote efficient but economic medical care to Medicare patients, the PSROs focused on cost cutting instead of peer review, costing the government millions of money without saving Medicare funds, and eventually had to be phased out in 1982 after the Reagan administration declared them a spectacular failure. The PSRO's progeny, the PROs (Peer Review Organizations), enacted in 1984 to promote quality of care and to save money for the government, have not quelled the uneasiness and fears of many physicians that bureaucrats with no knowledge of medicine are out to dictate to them how to practice their pro-

fession. Cookbook guidelines on how to treat certain medical diseases, inflexible criteria for admitting ill patients, questionable goals of reducing so-called avoidable deaths, inappropriate denials of payments to physicians, and superficial reviews of cases by non-qualified reviewers are some of the many problems that have surfaced since the program started two years ago. Unless these deficiencies are corrected, the suspicion will linger that the government is really not interested in promoting the quality of medical care, but in cutting costs at the expense of patients.

And what about the greatly promoted scheme of DRGs for hospitalized Medicare patients? While resident experts at HCFA have been crowing at the reduced hospitalization rates and hospital stays of Medicare patients, not to say the savings to the government, the growing body of data concerning the shortcuts in managing patients, the skimping of necessary services, the premature discharges, and the resulting compromise in the quality of care to patients is causing great concern both to physicians and patients. "Sicker and quicker" is how Senator John Heinz of Pennsylvania described a number of patients victimized by DRG guidelines during preliminary hearings on DRGs held in 1985 before the Senate Subcommittee on Aging.

If DRGs have not caught the imagination of physicians and patients, neither has the Medicare participating program launched in 1984 which has frozen the fees of 72% of non-participating physicians while their overhead costs continue to go through the ceiling. Scheduled to last for one year, it has been extended for another year until December 31 this year, clearly a typical example of the deception that the government has employed in its dealings with physicans. The program was started even after 80% of physicians voluntarily froze their fees in response to a call from the government. Even participating physicians have felt double-crossed in not being able to increase their Medicare fees as they were promised.

And while we talk about government insensitivity to physicians, what is one to say about the latest con game concocted at HCFA where physicians, patients, and medical suppliers are denied payments on time while the government finds it convenient to keep the money as long as possible because of the interest that it generates? To delay payments for a few additional bucks while patients and Medicare providers are trying to make ends meet is not only morally reprehensible, but smacks of an ethical vacuity where decision-makers in our society seek to justify the means for any end. The public has been outraged at this sinister display of authority, as well it should be, and has prompted several resolutions in Congress to put an immediate end to the practice. We have yet to see, at this writing, any resolution of the problem.

The attempts by the government to recast the Medicare program and make it viable sound admirable on the surface, particularly in the light of actuarial predictions that the program would go bankrupt if nothing was done to stop the hemorrhagic flow of dollars. Everybody understands that. But in the process of trying to solve its fiscal woes, great care must be taken to ensure that the proposed remedies do not adversely affect the quality of medical care nor trample on the traditional freedom of physicians to practice medicine. It would be hypocritical to say that physicians do not have any economic stake in this proposed revamping of Medicare; however, far more than the economic implications, physicians are increasingly restive over the usurpation of their power by government Myrmidons and sycophants and their decreasing role in the ability to make decisions for their patients. There are ominous signs that any further erosion in the independence of physicians will signal the end of free-enterprise medicine as we have known it and bring the day closer to socialized medicine.

The next battleground for Medicare opens next year when the Reagan administration and Congress consider various proposals aimed at cutting further expenses the next few years. The fee freeze will be over by then, but the lessons of recent history ought to dampen the enthusiasm of physicians who may want to celebrate the liberation from their bondage. Major proposals likely to be taken up include the adoption of capitation by Medicare, curbs and reductions of fees for various procedures and services, the establishment of uniform fee schedules, and the inclusion under DRGs of hospital-based physicians — all with the potential to change forever the face of medicine in this country.

1965 and 1986 are two disparate eras. There was jubilation then at the passage of the most sweeping health legislation in American history; now, twenty-one years later, the jubilation has been replaced by talk of bankruptcy and salvation. It is indeed a cruel hoax that Congress did not listen when AMA leaders warned that the uncontrollable costs of the program would be its own undoing. That day of reckoning is finally coming.

R. G. Lacsamana, M.D.
Editor

The drug problem: tilting with windmills

The mounting concern among Americans concerning the rise in illegal drug use in this country has prompted a number of proposed remedies, some vapid, others laughable, but all of them ineffective. Not even the suggestion that we punish drug dealers by using gallows will work; it has not worked in Malaysia and most civilized Americans will not know how to use the device anyhow. There is one reason for our consistent failure to eradicate the drug menace: we do not have the guts, the will, and the discipline to do what is needed and so the drug dealers and users are constantly outfoxing us.

The death of a well-known athlete, or of an actor, or of a rock singer usually mobilizes Americans in a collective frenzy of righteous indignation. But righteous indignation is not enough. After we let off steam by preaching, moralizing, and editorializing, the furor dies down and it is back to normal for the drug suppliers, the drug dealers, and the addicts. It is almost comical when we send a squadron of American soldiers to the Bolivian jungles only to find out that the poor Bolivian peasants have been growing poppies all along, in collaboration with officials, to support their national economy. We applaud a group of South American ministers meeting ostensibly to put a bust to the drug trade, knowing deep in our hearts that it is all a show. Indeed, when talking about the drug war, there is a lot to laugh about and to be frustrated about.

Statistics are frightening: there are at least seven million Americans who have used heroin, 30 million who have tried cocaine, and many times more that number who have used marijuana at one time or another. The recent availability of crack cocaine which predisposes to easier addiction is sure to boost these numbers. If this is not an epidemic, then I do not know what else to call it. While earlier epidemics killed thousands and even millions quite quickly, the current drug epidemic kills slowly; it also breeds crime, foments official corruption, tears families apart, and destroys the social fabric. Although drug use cuts into all lines of society, it affects most severely a segment of people who are perpetually lashed by poverty, crime, and unemployment: the poor and disenfranchised dwellers of ghettos and inner-city slums. The costs to society in terms of the shattered lives, school delinquencies, urban crimes, and a lingering sense of national despair are inestimable beyond the billions of dollars that the government spends yearly in fighting the drug war.

While illegal drug traffic is carried on throughout the world, it is mainly in the United States where the potential for huge profits lies, hence, the concentration here of all kinds of illegal drugs. There is a variety of reasons to explain why more Americans use drugs — easy availability of money, a Sybaritic streak in the American character for escape and adventure, boredom, a tolerant atmosphere, and lax laws — but they all add up to one thing: we do not have the courage and discipline to resist drugs and to lick the problem. Our fetish to do almost anything, unencumbered by traditional values that held Americans together in earlier times, makes it easy to be swayed by the blandishments that these drugs offer. The drug warlords from Colombia, Mexico, and other countries recognize this weakness in our character; as long as the national appetite is there, and there is no reason to suppose that it will disappear, illegal drug use, along with addiction, will continue to be a problem here.

This is not to disparage or criticize the efforts of those involved in fighting the drug problem. We need to doff our hats to them. But we do not need more rhetoric and political theatrics; we do not need more fancy solutions like mandatory drug testing for

arrogant athletes and unwilling bureaucrats. Along with what we have been doing, we need a renewed spirit to prick the national conscience, to gather the collective will, and to muster a new sense of pride and discipline, much in the same manner that we pooled our national resources in building America into a great nation, or in fighting for democracy in two world wars, or in waging the battle for civil rights. We may need a miracle to do this, but unless it comes, we will forever be tilting with windmills.

R. G. Lacsamana, M.D.
Editor

UNPARALLELED LUXURY!

BUY NOW BEFORE PRICE INCREASE!

Your Oceanfront Home-Away-From-Home

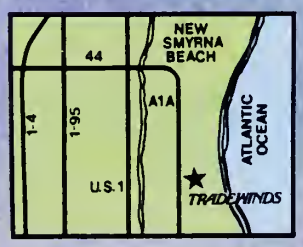


Fulfill your desire for an oceanfront second home... at The Tradewinds in New Smyrna Beach. It's an exclusive condominium community highlighting the very best in Florida living. The large, elegant apartments of **The Tradewinds** are designed with an overall emphasis on spacious comfort, lavish appointments and magnificent oceanviews. An array of recreational amenities are provided including custom-designed swimming pools, lighted tennis courts and a fully-equipped clubhouse. In addition, your new condominium home at **The Tradewinds** is backed by the worldwide reputation of Selmer Sande A/S Corporation.

The Tradewinds — luxurious by design. 2 bedrooms/2 baths (1,500 sq. ft. living area plus balcony), 3 bedrooms/3 baths (2,200 sq. ft. living area plus balcony) with private courtyard, and two-story penthouse with large roof garden complete with spa — starting from $186,000. Visit our fully furnished models at **The Tradewinds** today. You'll discover the oceanfront home-away-from-home you've always dreamed of.

OPEN MON. THRU SAT.
10 A.M. TO 6 P.M.
SUN., NOON TO 6 P.M.

Broker Participation Welcome



Interstate 4 to SR 44, east to A1A Highway, 4 miles south of 3rd Avenue in New Smyrna Beach.

TRADEWINDS
A CONDOMINIUM

(904) 427-6803

SELMER
A SELMER CORPORATION DEVELOPMENT
2211 E. Hillcrest, Orlando, FL 32803 Telex #52-3555

YES! I'd like more information about The Tradewinds!

Name _____
(please print)

Address _____

City _____ State _____ Zip _____

Telephone (_____) _____

Mail to:
Selmer Corporation
2211 E. Hillcrest, Orlando, FL 32803

OM

FIFTH ANNUAL CARDIOLOGY UPDATE '86

OCTOBER 17-19, 1986

SPONSORED BY THE:
SOUTHWEST FLORIDA HEART INSTITUTE
OF FORT MYERS COMMUNITY HOSPITAL

PROGRAM DIRECTORS:

HARVEY TRITEL, M.D., F.A.C.C.
RICHARD CHAZAL, M.D., F.A.C.C.

PRESENTED AT THE
SUNDIAL BEACH & TENNIS RESORT
SANIBEL ISLAND, FLORIDA

PROGRAM

FRIDAY, OCTOBER 17TH

"Myocardial Protection"
Robert Schlant, M.D.

"The Role of Spasm in Ischemic Heart Disease"
Michael Assey, M.D.

"Stratifying the Risk of Patients' Post-Myocardial Infarction"
Steven Scheidt, M.D.

"Calcium Blockers vs. Beta Blockers for Angina and Hypertension"
William Frishman, M.D.

"Streptokinase for the Acute MI"
Bill Rodgers, M.D.

Panel Discussion—"The Role of Invasive Procedures in the Acute MI"

SATURDAY, OCTOBER 18TH

Coffee & Danish—Richard Chazal, M.D.

"Emerging Concepts of Hypertension Therapy"
Julien L. Selfter, M.D.

"The Clinical Pharmacology of Beta Blockers in the Treatment of Complicated Hypertension"
David Lowenthal, M.D.

"New Anti-Arrythmics"
Leonard Dreifus, M.D.

"Congestive Heart Failure and the Role of Afterload Reduction"
James Spann, M.D.

"The Role of Amrinone in the Treatment of Congestive Heart Failure"
Carl Webber, M.D.

"Silent Ischemia"
Stephen Glasser, M.D.

GUEST LECTURE—"DIET AND YOUR HEALTH"
Vijaya C. Ratnesar, M.D.

GUEST LECTURE—"STRESS MANAGEMENT —A BRIEF OVERVIEW"

SUNDAY, OCTOBER 19TH

BREAKFAST—Harvey Tritel, M.D.

"The Role of Digitalis in the Cardiac Patient"
Nancy Flowers, M.D.

"Sudden Death"
Albert DelNegro, M.D.

"Expanding Indications for Angioplasty —Including Acute MI"
David O. Williams, M.D.

"Indications for Pacemakers"
William Miles, M.D.

"Lipids and Arteriosclerosis—An Overview"
Peter O. Kwiterovich, Jr., M.D.

PANEL DISCUSSION—"The Future Direction of Cardiology"

APPLICATION FOR ENROLLMENT

FIFTH ANNUAL CARDIOLOGY UPDATE '86

OCTOBER 17-19, 1986

Sanibel Island, Florida

PHYSICIANS: $240.00
NURSES: $ 90.00
PHYSICIANS ASSISTANTS: $ 90.00

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____

TYPE OF PRACTICE _____

Check made payable to the Southwest Florida Medical Foundation should accompany this enrollment application and be forwarded to: Registration Secretary, Fort Myers Community Hospital, 3785 Evans Avenue, Fort Myers, Florida 33901

For accommodations call Sundial Beach & Tennis Resort—800/282-3405. Special rates are available for Cardiology Update attendees.

The grapes of female wrath

I was offended and disturbed by Dr. Richard Restak's article entitled "We Need Doctors We Can Pay Less and Boss More — Namely Women" in the June 1986 issue of *The Journal of the Florida Medical Association, Inc.* Did you choose to reprint this piece on its educational merit, or rather for comic relief?

While I agree with Dr. Restak that the medical profession will only improve as the number of women physicians increase, I cannot swallow Dr. Restak's reasoning. He must have little ongoing contact with the average woman physician in private practice.

Yes, I believe women tend to show more compassion, humanism, and are more sensitive to a patient's anxieties, fears, and other emotions. But to generalize and classify the women physicians of the future as glorified nurses who will be molded into simple, salaried bureaucrats with no interest in independence and individuality is ridiculous, as is his forecast of a medical profession made up mostly of women who are compliant and easily regulated. Women in medicine may be part of the answer in lowering health care costs and making care more readily accessible, but certainly not because of his arguments.

I personally possess a strong independent and entrepreneurial streak. I will soon be leaving the comfort and shelter of practicing in a large multispecialty clinic as a salaried associate to open up a solo private practice and remain here in Florida — in Obstetrics and Gynecology no less! And unlike the women described, I am happily married to a social worker, whose profession traditionally does not generate a "respectable" income. But neither my husband nor I chose our respective professions based on earning potential. And I know countless women who are more similar to me than to the women of whom Dr. Restak speaks. We did not all "marry up" and we are not all cushioned by the lucrative salaries of our husbands, as Dr. Restak is led to believe. But then I am certainly not leaving my current practice arrangement because I stand to make more money; rather, I am doing it to offer a more personalized delivery of health care.

I certainly hope the general population of male physicians are not the arrogant, selfish professionals (his words, not mine) who are in medicine only for the power and the almighty dollar. I would also hope physicians of either sex are not in the field, or entering into medicine to become wealthy and influential, exclusivist and selfish. Dr. Restak certainly is.

It is more clear to me now after reading Dr. Restak's piece of the reasons for our current medical-legal crisis: too many physicians hold to Dr. Restak's ideals. American medicine needs more physicians that will increase the humanism within the profession — regardless of their sex. We need human beings to treat other human beings as such. We need physicians who are patient and understanding, and willing to listen as well as to speak. We should be stimulating our patients to ask questions; to better understand their bodies — their wellness and their illness. We need to be open to include them in on the decision making. When patients are told emphatically to carry out a doctor's order, and given no opportunity to make a choice, they have no one to blame but their doctors when the outcome is less than perfect. When the public is exposed to caring, compassionate professionals who explain options, they will realize decisions based on diagnostic techniques and therapeutic plans are complex. They will have a better perception that medicine is not an exact science. I think they will not develop such unrealistic expectations, and they will have a better grasp of the difference between a less than perfect outcome and medical malpractice.

Cost effective medical care does not have to be

likened to Russian society, as Dr. Retak has done. It will, however, require us to use a mindset that involves patients in the decision making. And one that involves caring physicians with less arrogance and less than the total autonomy of the past; physicians who are not wrapped up in the delusions of wealth and power. It is no wonder that medicine is in the state it is in. My recommendation to Dr. Restak is simple: "Retire and devote your time to managing your investments."

Yes, we need more women in medicine. In fact, (to quote Dr. Restak) a profession made up largely of women may be exactly what is necessary to provide the kind of health care system for which the government and the public seem to be clamoring. But more importantly, we need less Richard Restaks — regardless of their gender. I believe we can retain individuality and independence in our profession if we eliminate the egotism, and the need for power and wealth. So what is wrong with physicians who are flexible, cooperative, and capable of understanding anyway?

Heidi Marie McNaney, M.D.
Vero Beach

Editor's note: I reprinted Dr. Restak's article both for the light banter and the underlying message, whether serious or not, of the potential female domination of medical practice in the future. I am certain that Dr. Restak wrote with tongue in cheek, but I am also pleased that Dr. McNaney responded with righteous indignation and refreshing feminine aplomb at having been piqued by a male physician's viewpoints. If Dr. McNaney's tongue is as mighty as her pen, I am afraid Dr. Restak and company will have to stop writing funny pieces about women.

More on nursing homes

I thought it was incredulous when I read your editorial stating that physicians do not know the poor quality of nursing homes in this country and that they were surprised at the large number of nursing homes that were so poor. Any physician who has visited a nursing home knows the extremely poor quality of most nursing homes in his area. There are a few of us who have fought to make sure the nursing homes where we practice are top-notch and have been able to do so. Your whitewash of medicine in not realizing the poor quality of nursing home care is ridiculous to me.

George L. Ford Jr., M.D.
North Palm Beach

Editor's note: Dr. Ford obviously did not read my editorial or did not get the point right if he did. My editorial was an indictment of the substandard conditions in nursing homes, not a whitewash.

Musings of a rookie delegate

Although I have been a member of the AMA for some time, and even though I have always been active in my county medical society and the Florida Medical Association, I have been a card-carrying critic of the AMA. I somehow always felt that it was a "Good Old Boys" organization, held together mainly by a group of people who were more interested in maintaining their power than in representing us in mainstream medicine. I also had the perception that the delegations were not stratified, and that the young had no say-so in the organization. I am almost ashamed to admit that my first exposure to an AMA House of Delegates meeting was as an alternate delegate. One of the things that struck me was the handbook which I received as an alternate delegate. It is bigger than the New York City phone book or a medical textbook, and the most surprising thing was the top quality of information included in it. The information is well researched, well presented and is a wealth of useful materials concerning the issues of mainstream American medicine.

I have, of course, been to FMA Reference Committees, and been a member of multiple FMA Reference Committees, but I must admit that I was pleasantly surprised at the AMA Reference Committees. First of all, the committee I attended was well-coordinated, and the presenters were knowledgeable and articulate. I think, however, the most impressive thing about the Reference Committees was the quality of the council chairman and their members. These members were bright, intelligent, knowledgeable and pliable. They were also very practical practicing physicians who are well motivated, and intensely interested in the work of their committees. They were present to debate their position, but also pliable enough to change their position when it was apparent that they were wrong. It is also apparent from the Reference Committee meetings that the AMA Staff is a wealth of resources, waiting to be tapped.

Many members of the FMA feel that the delegates to the AMA are ancient and are beyond the ability to grasp new ideas. I must admit that I felt that they were much like the Roman Senate, many of them probably having to be brought in on stretchers in order to participate. In reality, there are indeed a good number of elderly statesmen. However, there is much better stratification than members of our county medical societies are led to believe. I would, at this point, like to dispel the idea that the AMA is not interested in young physicians (those under 40), and that they have no say-so. That is simply not the case. As a matter of fact, much effort was expended in caucuses of Reference Committees and in the House of Delegates in attempting to find the best way to incorporate the ideas of the young physician and to enlist his par-

ticipation. The controversy existed not in whether he should have a say-so, but what the best way is to allow him to get the say-so.

Your Florida delegation is a talented, conscientious, knowledgeable, and well stratified group, better stratified according to age, interests and medical training than many of the delegations that I was exposed to. We were, of course, in the throes of trying to elect Dr. Broadaway and Dr. Dockery to national office, and it did give the new delegates an opportunity to converse with a great many more delegates than we probably would have been able to under normal circumstances. The campaigns were honest, fair, democratic, and were totally without "shenanigans." I also really had no idea that being a delegate was such hard work.

Our caucuses began at 6:30 or 7:00 in the morning. The major issues were discussed in detail, and Dr. Donegan, as the Delegation Chairman, is to be commended for the fair way he ran the committee and in having the demeanor that encourages participation by all. The House of Delegates reminds one of the Senate of the United States. It is the most democratic organization that I have had the privilege of witnessing in operation. The oratory was impressive, the debates were enthusiastic, and some of the participants were very interesting and entertaining. Some sounded like prominent people. For instance, one sounded exactly like Heywood Hale Broun, and the President, Dr. Rogers, sounded like David Brinkley. All aspects of American medicine were vigorously considered. This covered a breadth of subjects from our legal endeavors in three prominent lawsuits filed on behalf of medicine to the debate over alcohol, tobacco, and what should be carried as emergency equipment on airplanes. It was truly amazing to listen to the debates as they were heated, performed by very knowledgeable people who presented their points with vigor. Of course, economic options were the subject of long and heated debates, as they should have been, and convinced me that they are not out of touch with our problems. It is just that they are complex problems and not easily solved, varying to a great extent throughout the United States. I was impressed that the speaker and the vice-speaker were superb parliamentarians. The speaker, Dr. Davis, is the most effective chairman I have ever known, and he is to be complimented not only for his knowledge but for his quick wit, which made for frequent releases of tension in a situation where tempers were often controlled only on the surface.

In summary, I found the House of Delegates, contrary to my previous misconceptions, to be a place where stratified representation exists. I, of course, being the critic that I am, do not think that it is perfect, but I do think that the delegates are trying to represent mainstream American medicine as best they can. This task is being carried out by people who are interested, persistent, bright, knowledgeable and fair. One of the major misconceptions I had was that young physicians had no place; that is simply not true, and it is anticipated that they will have even greater representation in the near future.

I left the First AMA House of Delegates Meeting convinced that we do have a representative organization and that it does respond if properly stimulated. Like every other organization, it can be changed, but it can only be changed by the members who are interested and who are willing to participate. It is no longer a "Good Old Boys" club, but an effective organization, requiring only our interest and participation to make it a better representative body of mainstream American medicine.

Alvin E. Smith, M.D.
Ormond Beach

TURP necessary

Re: "Severe post-TURP syndrome in patient with renal insufficiency; treatment with hemofiltration", May, 1986; and the letter concerning that article in July, 1986 from R.T.E.

The reason the patient underwent transurethral prostatectomy was that he had recurrent painful symptoms of outlet obstruction; these were completely relieved by the surgery.

Although urine output often declines in advanced renal insufficiency, some patients continue to produce moderate volumes of urine even years after dialysis has been initiated to control uremia. This is sometimes an advantage for the patient since it can simplify fluid management; for those with prostatic problems or recurrent nephrolithiasis it merely extends the period in which they can experience recurrent morbidity.

Stephen Sandroni, M.D.
Jacksonville

For Your Benefit...

From The Florida Medical Association Sponsored Insurance Plans.

Diagnosis: FMA Members and Employees, Need Dependable, Comprehensive Coverage In Medical Care, Life, Disability and Dental At Economical Group Rates

Treatment: Enroll NOW in Your Florida Medical Association Sponsored Insurance Plans

Prognosis: Excellent. FMA-SIP Offers Flexibility, Convenience, Efficiency In An Insurance Package Designed Exclusively For You.

•Major Medical •Dental
•Short-Term Disability
•Life And AD&D

☐ Developed from your specifications by your Association and offered exclusively to FMA members and their employees. Dependents coverage available for Medical and Dental benefits.

☐ Marketing by Florida's leading insurance consultant, Brown and Brown, Inc., for further information contact us at the toll free number below.

☐ Underwritten by one of America's largest and strongest insurance companies, Mutual of Omaha.

☐ Administered by FLAMEDCO, Inc., highly regarded for rapid, efficient claims and enrollment administration and a wholly owned subsidiary of your own Florida Medical Association.

FMA/SIP Offers You Great Flexibility. You Choose The Coverage You Need:

Major Medical, Million-dollar protection with your choice of $200 or $500 annual deductibles and the new Medical Deluxe Plan.

Dental, Benefits of up to $1,000 per person each year. Optional if you elect Major Medical.

Life, Group term life insurance coverage for you and your employees. You select coverage level from $10,000 to $100,000.

Disability, If you elect life insurance, you also may choose from among four short-term disability options, either 13-week or 26-week coverage with or without maternity.

Call Toll-Free
1-800-624-3953 *For Details*

P.O. Box 4938
Jacksonville, Florida 32201



Florida Medical Association, Inc.
Sponsored Insurance Programs

How To Keep Your Electronic Equipment From Feeling Down And Out.



WHEN STORMY WEATHER STRIKES, SENSITIVE ELECTRONIC EQUIPMENT SUFFERS.

Thunderstorms, surges and split-second voltage changes can cost you lost data. Output errors. Even damaged hardware...unless you get protection.

That comes from STEDI-STATE Power Conditioning. If you're a Florida Power customer, our Energy Experts will keep you up and running with a free service call. That means visiting your location, identifying problems and finding the answers.

If appropriate, they'll also install monitoring equipment. Recommend the products you need, from voltage regulators to backup battery systems. Even arrange for delivery and skilled installation.

And the Energy Experts will *stay* on your team, ready to assist when you need greater capacity or future modifications. Call Bob Phillips, Power Conditioning Program Coordinator, 1-800-445-3320 toll-free for information on STEDI-STATE Power Conditioning.

We'll prove that bad weather can't keep a good machine down.

Florida Power
CORPORATION

Call the Energy Experts at 1-800-445-3320.

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

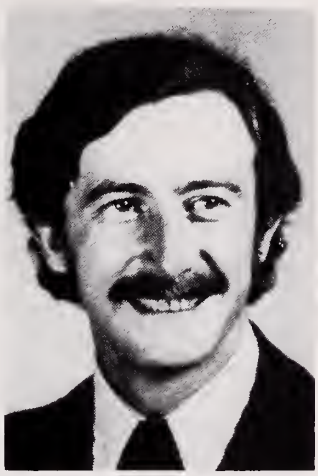
GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC.
P.O. BOX 2411, JACKSONVILLE, FL 32203
TELEPHONE 904/356-1571

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
AUGUST 1986, Vol. 73, No. 8

Sports medicine: a growing specialty



It is difficult at present to define the scope of Sports Medicine, but certainly the concept has evolved from the stage where it meant only the local orthopedist serving as high school team physician. In large part, this evolution was mandated by changes in society. The public's growing awareness of exercise as a means of promoting good health, the changing role of women in society, and the increasing average age of the populace are creating a much larger pool of patient-athletes of all ages, as well as a new range of medical problems that physicians of all specialties will be treating. Technological advances have provided new ways to understand exercise physiology and also improved diagnostic and treatment modalities that we all need to be aware of. In truth, Sports Medicine today means not only treating sports-related injuries, but also understanding how exercise can affect the natural history and treatment of the whole range of medical and surgical disorders.

With this in mind, the Sports Medicine Symposium sponsored by the Indian River County Medical Society provided presentations from both medical and surgical subspecialists (some of which will appear in this month's *Journal*) that will better enable not only the orthopedist, but also the family practitioner, ob-gyn, internist, and surgeon to better diagnose and treat sports-related conditions.

John W. McDonald, M.D., Director
Sports Medicine Symposium
Chairman, Continuing Medical Education
Indian River County Medical Society

Ocular injuries in sports

Marcos T. Doxanas, M.D.

The ophthalmologist plays an important role in the care of an athlete. The ophthalmologist can maximize the visual efficiency of the athlete, and treat any ocular injuries which may occur. This report addresses the role of the ophthalmologist with the athlete. Three areas will be covered: 1) The Correction of Visual Acuity, 2) Ocular and Adnexal Injuries and, 3) Prevention of Ocular Injuries.

Correction of visual acuity • Routine visual screening for athletes should consist of determination of visual acuity, peripheral vision and stereopsis (depth perception). The visual acuity is measured by standard Snellen chart and measured at a distance of twenty feet. A reading card assesses near vision. Abnormalities in distance visual acuity are classified as myopia (near-sighted) or hyperopia (far-sighted). In myopia the object is focused in the front of the retina because the eye is elongated or the refractive power of the eye is too strong. In hyperopia, the object is focused behind the retina, either because the eye is too short or the refractive or focusing power of the eye is too weak. The correction of visual acuity focuses the object on the retina.

The correction of visual acuity is by either glasses or contact lenses. A visual correction with glasses offers a safety benefit shielding the eyes from direct injury. However, glasses are considered cumbersome by some individuals. Thicker glass lenses also produce peripheral visual field distortion which reduces the quality of visual acuity. Contact lenses offer the benefit of visual correction placed directly on the cornea. The quality of visual acuity is enhanced in the patients with large refractory errors (thick glasses) by eliminating peripheral field distortion. Also, the cumbersome effect of glasses is eliminated. Contact lenses are available in two forms: hard or soft. Recent advances in contact lens technology are reducing the distinction between these contacts. Hard contact lenses are able to produce a greater refinement of visual acuity; however, sacrifices are made in comfort, or tolerance of the contact lens itself. In particular, dusty environments create a severe foreign body reaction with hard contact lenses. Soft contact lenses generally adequately correct visual acuity, however, are much better tolerated in potentially dusty environments so are recommended in outdoor sports.

Radial keratometry has been recently introduced in the United States for the correction of myopia. This surgical procedure places fine radially oriented slits in the cornea reducing its curvature. Radial keratometry has problems in its predictability, of variability in visual acuity, and even its permancy. However, in regards to athletes, the greatest concern of radial keratometry is the potential weakening effect on the cornea. The incisions are approximately 70-80% corneal thickness, therefore seriously jeopardizing the ability of the cornea to withstand even minor trauma. As such, radial keratometry or refractive surgery should be discouraged in any athlete.

Ocular and adnexal injuries • A knowledge and appreciation of ocular and eyelid anatomy is an important consideration in the evaluation of ocular injuries. Distinguishing features or symptoms of ocular injuries which indicate a significant abnormality are

The Author
MARCOS T. DOXANAS, M.D.
Dr. Doxanas, an oculoplastic surgeon, is Chairman, Department of Oculoplastics, Greater Baltimore Medical Center, Baltimore, MA, and with the Florida Eye Institute, Vero Beach.

the reduction of visual acuity and ocular pain. Visual acuity is the vital sign of the eye and any reduction of visual acuity has to be explained. Any interference in the optical axis will produce a reduction of visual acuity. This may be a superficial corneal abrasion or as severe as a hemorrhage within the eye, retinal edema or detachment.

Sensory fibers to the eye are localized to the superficial cornea and the ciliary body within the eye itself. The symptom of pain signifies either an interruption of the corneal epithelium exposing the sensory nerve fibers, or a spasm of the ciliary body. If the corneal epithelium is abraded, shining a bright focused light beam at an angle across the cornea will cast a shadow onto the iris allowing its detection and corneal foreign bodies can be visualized directly. Many foreign bodies will become lodged under the upper eyelid, so eversion of the upper lid is required to locate the retained foreign body. To evert the upper eyelid, the patient is asked to look down and the eyelash is grasped with a thumb and forefinger. A cotton tipped applicator is used to depress the eyelid approximately 10 mm above the eyelid margin as the eyelid is gently pulled outward and upward. The eyelid then easily everts and the foreign body embedded in the tarsal conjunctiva can be visualized. Chemical injuries to the eyes should be thoroughly irrigated as soon as possible to avoid serious ocular injuries. The irrigating solution would preferably be a balanced saline solution; however, tap water is acceptable to flush the eye of remaining particulate matter. Alkali injuries (lime) can be self-perpetuating once initiated, so thorough irrigation of the eye is essential to reduce the possibility of serious ocular injury.

Eyelid injuries consist primarily of hematomas and lacerations. The loose connective tissue system of the eyelids permits the diffusion and extension of hematomas. Localized contusions of the orbital area frequently result in extreme bruising in the periocular area. Localized hematomas are rare, but if large, these may induce irregular corneal astigmatism and produce a reduction in visual acuity. Eyelid lacerations necessitate a systematic approach. Eyelid lacerations of concern are those involving the eyelid margins, punctures and those in the medial canthal area. Medial canthal lacerations may involve the canaliculus or tear excretory system and should be repaired primarily. If lacerations are of concern, they should be referred for proper evaluation and treatment.

Injuries to the orbit consist of fractures to the orbital rim or the bony orbital walls. Direct injuries to the orbital rim, especially laterally, may produce a localized fracture to the rim (trimalar fracture). A diffuse injury to the orbit may compress the ocular contents and produce a localized fracture to the orbital floor (blow-out fracture) or a medial wall fracture of the orbit. These patients will frequently exhibit numbness in the distribution of the infraorbital nerve and anterior superalveolar nerve and limitation of ocular motility and occasional anophthalmos after the initial orbital edema and hemorrhage subside. Most orbital rim fractures necessitate surgical repair while orbital floor fractures are repaired only if there is restricted ocular motility (with positive forced suction testing) and anophthalmos. The eyeball should be evaluated in all injuries to the bony orbit to rule out ocular injury which occur in approximately 25% of cases.

If a reduction of visual acuity or ocular pain cannot be explained, the patient should be referred to an ophthalmologist for proper evaluation.

The Society for the Prevention of Blindness estimated approximately 165,000 ocular injuries in school age children in 1976. They concluded approximately 90% of these injuries were preventable. The ophthalmologist should not only correct visual acuity, treat ocular injuries, but have an active role in the prevention of ocular injuries.

Eye protection is recommended in sports with a predisposition to ocular injuries, which include racquet sports, and especially hockey. One-eyed patients should be strongly encouraged to wear safety glasses to minimize their risk of ocular injuries.

● Dr. Doxanas, Florida Eye Institute, 2750 Indian River Blvd., Vero Beach 32960.

Effects of exercise in diabetes mellitus

John T. Devlin, M.D.

Physical exercise has long been promoted as part of the therapeutic regimen for the treatment of diabetes mellitus, in particular non-insulin dependent diabetes. The usual treatment modalities include dietary therapy, physical exercise programs, and if necessary, oral hypoglycemic drugs or insulin. Most of my discussion will focus on type II or non-insulin dependent diabetes mellitus (NIDDM), which is a disease characterized by insulin resistance.

Insulin resistance produces two effects, depending upon the tissue involved. In the liver, the result is increased glucose production especially in the fasting state, accounting for fasting hyperglycemia in diabetes. In peripheral tissues, primarily skeletal muscle, insulin resistance results in decreased glucose uptake following a glucose load.

Therapeutic efforts to decrease insulin resistance have focused primarily on hypocaloric, weight reduction diets and on physical exercise. Benefits of exercise include lowering of blood sugar, increases in insulin sensitivity, improvement of lipid profiles, improvements in blood pressure, decreased cardiac work, and increased sense of well-being.[1]

Exercise in diabetes is not without risks, however. These include hypoglycemia in insulin treated diabetics,[2] increased ketone body production and blood sugar levels in poorly controlled diabetics,[3] and the possibility of myocardial infarction or arrhythmias in patients with ASCVD. The ability of exercise to lower blood sugar was shown in 1926 by R.D. Lawrence,[4] demonstrating clearly that exercise could potentiate the blood sugar lowering effect of insulin. Recently, investigators have shown that much of this blood sugar lowering effect of exercise is related to enhanced absorption of insulin from subcutaneous depots, resulting in inhibition of the usual augmented hepatic glucose production during exercise.[5] The difficulties with increasing hyperglycemia and ketosis occur in poorly controlled insulin dependent diabetics, usually with antecedent glucose levels greater than 300 mg/dl. Clearly these hazards are much greater in the insulin treated diabetic, in particular the type I, insulin-dependent diabetic.

Because of the improvements in glucose control seen in non-insulin dependent diabetics with exercise training,[6] we and other investigators have been interested in the mechanisms accounting for this improvement. Physical training has been shown to increase glucose disposal, as measured during "insulin clamp" studies using a constant infusion of insulin with variable glucose infusion rates to maintain the blood sugar level at basal concentrations. Significant improvements have been found with physical training when compared to a group of obese diabetics treated with diet alone.[7] Recently it has been shown that much of the improvement of glucose uptake found after physical training is lost within several days after stopping training. We have been very interested in studying how quickly the improvements in glucose metabolism can result after brief bouts of exercise. In a recent study[8] we found significant improvements in total glucose uptake 12-16 hours after a single episode of intense bicycle exercise in obese, insulin-resistant subjects. This increased glucose uptake was the result entirely of increased non-oxidative

The Author
JOHN T. DEVLIN, M.D.
Dr. Devlin practices Internal Medicine-Endocrinology and Metabolism, and is Assistant Professor of Medicine, University of Vermont College of Medicine, Burlington, Vermont.

glucose disposal, which was felt to be the result of glucose storage as glycogen in the post-exercise state. These improvements in glucose metabolism shortly after a single bout of exercise have recently been found to occur in type II, NIDDM subjects also.[9] The magnitude of this increase in glucose uptake in NIDDM was similar to what has been previously been reported to occur after a physical training program. Therefore a single bout of intense, glycogen-depleting exercise may produce significant improvements in glucose metabolism for at least 12-16 hours afterwards.

We have also been interested in the ability of acute exercise to improve hepatic sensitivity to insulin since this organ is probably the major contributor to fasting hyperglycemia in NIDDM subjects. We found that a single bout of exercise was able to normalize hepatic sensitivity to insulin in diabetic subjects 12-16 hours later.[9] Therefore, both peripheral (skeletal muscle) insulin resistance and hepatic insulin resistance were improved in type II diabetics for at least 12-16 hours after a single bout of exercise.

As mentioned, there are certain hazards of exercise in diabetics. The tendency for insulin-treated subjects to develop hypoglycemia[2] may be present not only during exercise but for several hours afterwards. Early studies suggested that injecting insulin into a non-exercising limb could help protect against hypoglycemia. More recently it has been shown that the site of injection is only of importance if exercise occurs within 30 minutes of injecting insulin. We advise our insulin treated diabetics to omit their short acting insulin and decrease their intermediate acting insulin by ⅓ if they are exercising shortly after a dose of insulin. Subsequent doses of insulin, and the need for supplemental caloric intake, can be guided by home glucose monitoring during and after exercise.

The tendency for poorly controlled diabetics to develop increased hypoglycemia and ketosis[3] is best managed by advising insulin dependent diabetics not to exercise if their pre-exercise plasma glucose levels are 250 mg/dl or greater. Since recent studies fail to demonstrate an improvement in glycemic control in type I, insulin dependent diabetics after physical training, we do not strongly advocate physical exercise as a means to improved diabetic control in these subjects. Rather, in type I diabetics who wish to exercise for other beneficial effects, including improved lipid profiles and blood pressure, we try to devise exercise regimens allowing them to exercise more safely. This is in distinction to the type II, NIDDM subject where we feel exercise training programs play a central role in the treatment of the diabetic state.

Other risks in diabetics who exercise include the risk of vitreous hemorrhage or retinal detachment in subjects with proliferate retinopathy. Subjects with nephropathy may have some increase in proteinuria during and after exercise, which is of uncertain significance. Subjects with peripheral neuropathies involving their feet should avoid exercise which causes trauma to the feet.

Diabetic subjects who wish to undergo physical training should receive a thorough medical evaluation, including detailed history and physical examination, with particular attention to complications of diabetes. Exercise stress testing should be performed in subjects over 40 years of age or with duration of diabetes greater than 10 years. As with other exercise programs, subjects should begin slowly and build up to regular participation 3-4 times per week. If subjects have significant atherosclerotic cardiovascular disease or unstable blood glucoses then supervised training programs are indicated. Cardiac rehabilitation programs may be very appropriate for these subjects if they are available.

In summary there are numerous benefits to diabetic subjects who exercise regularly. These include increased insulin sensitivity and improved glycemic control in non-insulin dependent diabetics. In both non-insulin dependent and insulin-dependent diabetics there may occur improved plasma lipid levels, lower blood pressures, increased cardiovascular fitness and a greater sense of well-being. Obese diabetics who are attempting to reduce body weight with hypocaloric diets may find an additive effect of exercise to the hypocaloric diet.

The hazards of exercise in diabetics are most frequent in insulin-treated subjects, including hypoglycemia and exacerbation of poor control in type I diabetic subjects. Subjects with either microvascular or macrovascular complications of diabetes need to be carefully evaluated before instituting an exercise training program, and advised as to the appropriateness of particular forms of exercise for each individual.

References

1. Devlin, J.T. and Horton, E.S.: The Role of Exercise in Diabetes Mellitus, Cardiovascular Medicine 10:65, 1985.
2. Kawamori, R. and Vranic, M.: Mechanism of Exercise-Induced Hypoglycemia in Depancreatized Dogs Maintained on Long-Acting Insulin, J. Clin Invest 59:331, 1977.
3. Berger, M.; Berchtold, P., and Cuppers, H.J., et al: Metabolic and Hormonal Effects of Exercise in Juvenile Type Diabetes, Diabetologia 13:355, 1977
4. Lawrence, R.D.: The Effect of Exercise on Insulin Action in Diabetes, Br Med J 1:648, 1926.
5. Koivisto, V.A. and Felig, P.: Effects of Leg Exercise on Insulin Absorption in Diabetic Patients, New Engl J Med 298:77, 1978.
6. Trovati, M.; Carta, Q., Cavalot, F.; Vitali, S.; Banaudi, C; Lucchina, P.G.; Fiocchi, F.; Emanneli, G.; Lenti, G.: Influence of Physical Training on Blood Glucose Control, Glucose Tolerance, Insulin Secretion, and Insulin Action in Non-Insulin-Dependent Diabetic Patients, Diabetes Care 7:416, 1984.
7. Bogardus, C.; Ravussin, E.; Robbins, D.C.; Wolfe, R.R.; Horton, E.S., and Sims, E.A.H. Effects of Physical Training and Diet Therapy on Carbohydrate Metabolism in Patients with Glucose Intolerance and Non-Insulin-Dependent Diabetes Mellitus, Diabetes 33:311, 1984.
8. Devlin, J.T. and Horton, E.S · Effects of Prior High-Intensity Exercise in Glucose Metabolism in Normal and Insulin-Resistant Men, Diabetes 34:973, 1985.
9. Devlin, J.T. and Horton, E.S.: Effects of Prior Exercise on Glucose Metabloism in NIDDM, Diabetes 34:93A, 1985.

● Dr. Devlin, University of Vermont College of Medicine, Given Building, Burlington, Vermont 05405.

The benefits and reproductive risks of exercise to women

G. Rodney Meeks, M.D.

During the past decade, a fitness boom has occurred in the United States. This trend has been most striking in the female segment of our population. A generation ago, few women worked and vigorous participation in sports activities was openly discouraged. Generally, women found their place in the home with a sedentary lifestyle rearing children. Women now comprise approximately one-half of the work force, and they have become involved in the fitness boom sweeping the nation. Women also are involved in strenuous competitive athletic feats which require intense training and high fitness levels. One of the reasons so many women are now involved in exercise is to pursue the fashionable goal of slimness. The following discussion will emphasize the relationship of exercise and reproductive function. To evaluate the effect of exercise on a woman's reproductive system, one must ask: 1) What are the benefits of exercise? 2) What are the risks of exercise? 3) Is there an optimal body weight and fat-to-lean tissue ratio? 4) Is fertility related to body habitus?

The most immediate benefit of exercise is an increase in fitness level. That is, a person who exercises on a regular basis can perform increasing amounts of work without suffering fatigue. This is especially true of aerobic exercise, and indeed the amount of work that a well-trained person can accomplish can be striking. Moderate degrees of exercise can alter serum lipids. Moderate running has been documented to reduce triglycerides and total cholesterol.[1] Moreover, the ratio of the high-density lipoprotein fraction of cholesterol to the low-density lipoprotein fraction is increased. These changes are thought to be associated with a reduced risk of cardiovascular heart disease. Additional benefits are an improvement in one's overall sense of well-being, the psychological benefit of accomplishing a goal, and improved performance in one's daily life.

Perhaps the single biggest risk of exercise to women at all stages of their lives is injury. Most of these injuries involve overuse syndromes where the body is unable to repair sustained low-grade trauma. Additionally, injuries such as twisted ankles, other ligamentous strains and muscle tears are common. Only recently has the effect of exercise on a woman's reproductive system been evaluated.

Puberty is a variable event occurring between ages 8 and 16 in most women. Perhaps the single most significant occurrence during puberty is the onset of menses. Malina,[2] in 1976, compared menarche in women who were deemed nonathletes to those who participated in high school athletics and to those who competed in college athletics and those who were olympians. A significant difference was noted between the nonathlete and the girls who competed. The nonathlete, however, had a menarche very similar to the national norm. Frisch,[3] in 1981, noted a similar delay of menarche in swimmers and runners who trained extensively prior to the initiation of puberty. Menarche in the nonathlete study was approximately 12.5 years, which is the national norm, while menarche occurred at approximately age 15 in those individuals exercising strenuously. These two papers do not conclusively prove that exercise delays menarche. One could argue that women who have late menarche are more likely to be athletes. When one

The Author
G. RODNEY MEEKS, M.D.
Dr. Meeks is with the Department of Obstetrics and Gynecology, University of Mississippi Medical Center, Jackson, Mississippi.

evaluates puberty in the athlete or nonathlete, one should remember the cardinal signs of abnormal puberty. These are 1) no menses by age 16, and 2) no secondary sexual characteristics by age 14.

Menstrual irregularity occurs in 5% of the general population of reproductive women. However, if one confines the population of reproductive women to athletes, over 20% have menstrual irregularity. It would appear then that women who exercise on a regular basis have a higher incidence of menstrual irregularity. The causes of menstrual irregularity have been postulated as: 1) strenuous exercise, 2) a low percentage of body fat, 3) stress, 4) an unusual diet, and 5) an energy drain. Women involved in sports which favor a low percentage of body fat have a higher incidence of menstrual irregularity. Distance running, hurdling, gymnastics and ballet, in particular, are associated with not only menstrual irregularity but also amenorrhea. The percentage of body fat in these athletes varies from 6%-16% while the norm for nonathletic women is approximately 22%-25%. Women participating in swimming, speed skating, softball and basketball seem to have normal body fat percentages; however, they continue to have more menstrual irregularity than the general population. The intense training schedule with strenuous exercise and energy drain has been postulated as the etiology of these menstrual irregularities.

Menstrual disturbance follows a very characteristic pattern. Normal menstruation is associated with a normal follicular phase and a normal luteal phase on basal body temperature. This is followed by a prolongation of the follicular phase which is associated with a shortening of the luteal phase. Eventually, euestrogenic anovulatory amenorrhea or oligomenorrhea begins. Lastly, hypoestrogenic amenorrhea occurs. These changes in ovarian function may be on the basis of changes in the concentration of other hormones such as prolactin, cortisol and beta-endorphin. This model of normal menstrual function progressing to abnormal menstrual function and ultimately amenorrhea has been documented in athletes, especially in runners. The risks have been documented in women who exercise to the point of producing menstrual irregularity. During the first phase of ovulatory dysfunction, infertility and/or fetal wastage can occur. During the euestrogenic anovulation phase, endometrial hyperplasia can develop as a consequence of unopposed estrogen stimulation on the endometrium. During the hypoestrogenic phase, women can develop classic symptoms of estrogen deficiency which include atrophic vaginitis and urethritis, hot flushes and a susceptibility to osteoporosis and bone fracture.

One must, however, evaluate oligomenorrheic and amenorrheic women thoroughly even though they may exercise vigorously. A general history should be obtained with specific emphasis on the patient's menarche and puberty, length of training, competitive nature of the training, and the development of amenorrhea. A general physical examination with emphasis on height, weight and percent of body fat are important. An examination to insure that normal female genitalia are present is essential. A progesterone challenge test will aid in determining whether or not the patient has an adequate estrogen level. The diagnostic evaluation of athletes with oligomenorrhea or amenorrhea should include the possibility of hyperprolactinemia, hyperandrogenism, hypothyroidism, premature ovarian dysfunction and central nervous system tumor. Special laboratory exams include evaluation of prolactin concentration, a thyroid panel, follicle stimulating hormone concentration and luteinizing hormone concentration. Treatment in this group of women is aimed at the prevention of endometrial hyperplasia by giving a progestational agent to euestrogenic women. Prevention of the estrogen atrophy symptoms requires estrogen replacement and then progestational therapy to prevent the adverse effects of unopposed estrogen.

Infertility may result from weight control practice. Bates and Whitworth[4] in 1982 reported on a group of infertile women and a group of women with menstrual dysfunction. These women were 91% and 89% of ideal body weight respectively. They were evaluated to exclude other etiologies for infertility or menstrual irregulartity and then were treated by simple weight gain. Twenty-six of the 29 infertile women gained weight to approximately 100% of ideal body weight. The weight gain averaged 8.5 pounds. Twenty-three (88%) of the women who gained weight subsequently became pregnant. In the group experiencing menstrual irregularity, approximately one-half did not attempt to gain weight. This reflects a desire to maintain their fashionably thin body habitus and the fact that the motivating factor of pregnancy was not present. However, of the ten women gaining an average of ten pounds, all had a return to normal menstrual function. Evidence that maintaining an ideal body weight is necessary for normal menstrual function is further proven by evaluating the serum LH and FSH concentrations and the LH/FSH ratio in women below ideal body weight. In women whose ideal body weight was less than 85%, the LH/FSH ratio was less than 1.5, and all these women were characterized by anovulatory patterns. In those women between 85% and 95% of ideal body weight, the LH/FSH ratio exceeded 3.5, and the menstrual cycle had a luteal phase defect. Those women who had ideal body weights in excess of 95% had an LH/FSH ratio for 2.5 and had normal menstrual function.[5] One can, therefore, answer the questions of ideal body weight and reproduction. It would seem that there is indeed an ideal body weight at which menstrual function appears to be normal. A corollary of this would be that women who are less than ideal body weight experience menstrual irregularity and infertility. The ideal body weights utilized in Bates' study were taken from

the Safety Education Division of the Metropolitan Life Insurance Company.

Because many women are fitness buffs and avid exercisers, the question of pregnancy and exercise becomes important. Acute maternal response to aerobic exercise includes increased catecholamines, increased lactate, decreased glucose and decreased uterine blood flow (by as much as 25%).[6] The maternal benefit of exercise is an increased cardiac reserve manifest by a lower maternal heart rate, lower systolic blood pressure, increased maximum oxygen consumption and an increase of aerobic capacity of up to 20%. During these periods of exercise, fetal bradycardia can be monitored. This may be a response to increased catecholamines, decreased glucose or reduced oxygen. Following exercise, fetal tachycardia is noted, and this may be a compensatory response to the bradycardia of exercise. Endurance runners seem to have increased incidence of cesarean section, a lower mean birth weight and an earlier gestational age at the time of delivery.[7] The significance of these findings is not known, but it is known that women who exercise vigorously, either because of their work or job requirements, do have an increased incidence of preterm delivery and of low birth weight infants. Certainly, one could extrapolate these findings to those women who have intense exercise patterns and who are competitive athletes. Hyperthermia has been postulated to be associated with fetal anomalies. It seems that hyperthermia which involves an increased core temperature of .3°-.5°C may be associated with fetal anomalies. This degree of increased temperature can be associated with jogging, running, aerobic dance and the use of a hot tub or sauna. While all the implications of exercise during pregnancy have not been proven, several recommendations are currently made. 1) Exercise should be limited to short intervals followed by rest and should be aerobic. 2) Women should reduce the amount of exercise as pregnancy advances, especially beyond 36 weeks. 3) Pregnant women should utilize a warm-up and cool-down period and avoid becoming overheated and overtired. 4) Finally, resting following exercise in the recumbent left-sided position for a minimum of 10 minutes may allow the fetus to compensate appropriately for the stress of exercise.

The number of women who are exercising regularly is ever increasing. Not only are women exercising in a recreational manner, many are becoming competitive athletes. The benefits of exercise in terms of fitness are well-documented. The lipid profile takes on a pattern associated with reduced cardiovascular arthrosclerosis, although this has not been absolutely proven to reduce the incidence of cardiovascular heart disease. The enhanced self-image and sense of well-being are definite psychological benefits. The risks involve overuse injuries and injuries associated with increased activity and/or competition, such as ligament strains, muscle tears and fractures. The reproductive system is particularly vulnerable to strenuous exercise, weight loss and alteration of body fat to lean mass composition. Prepubertal women who are involved in athletics have a significant delay in menarche. Reproductive-aged women who compete in athletic events experience a significant increase in menstrual irregularity. This is particularly true in those sporting events which place a premium on thinness, such as running, gymnastics and ballet. As the level of exercise increases, there is a well-documented pattern of menstrual change. Normal menstrual function is followed by prolonged follicular phase and short luteal phase. Next, normal estrogen production but anovulation occurs, and lastly, loss of ovarian function with hypoestrogenism typical of menopause occurs. At least part of the reproductive changes can be attributable to less than ideal body weights. Infertile women who are below ideal body weight can achieve normal menstrual function by gaining to their ideal body weight. The effects of exercise on pregnancy are not well-documented. Certainly, in those women who have an intense workload because of cultural habits or their occupational workload, there is risk for premature labor and low birth weight infants. In theory, women who exercise vigorously may also have similar problems.

References

1. Wood, P.D.; Haskell, W.L., and Stern, M.P., et al: Plasma Lipoprotein Distributions in Male and Female Runners, Ann NY Acad Sci 301:748, 1977.
2. Malina, R.M.; Harper, A.B., and Avent, H.H., et al: Age at Menarche in Athletes and Nonathletes, Med Sci Sports 5:11, 1973.
3. Frisch, R.E. and Revelle, R: The Height and Weight of Girls and Boys at the Time of Initiation of the Adolescent Growth Spurt in Height and Weight and the relationship to Menarche, Hum Biol 43:140, 1971.
4. Bates, G.W.; Bates, S.R., and Whitworth, N.S.. Reproductive Failure in Women Who Practice Weight Control, Fertil Steril 37:373, 1982
5. Bates, G.W.; Meeks, G.R., and Gookin, K.S., et al: Effects of Weight Gain on Serum Gonadotropins in Slender, Infertile Women, Proc Soc Gynecol Invest 30:74, 1983.
6. Morris, N.; Osborn, S.B., and Wright, H.P., et al: Effective Uterine Blood Flow During Exercise in Normal and Preeclamptic Pregnancies, Lancet 2:481, 1956.
7. Dale, E.; Mullinax, K.M., and Bryan, D.H.: Exercise During Pregnancy: Effects on the Fetus, Can J Appl Sport Sci 7:98, 1982.

- Dr. Meeks, Department of Obstetrics and Gynecology, University of Mississippi Medical Center, 2500 North State Street, Jackson, Mississippi 39216-4505.

Overuse syndrome

Donald L. Ames, M.D.

Athletic injuries are caused by either of two mechanisms: 1) single impact macrotrauma (acute injury); or 2) repetitive microtrauma (overuse injury).

Acute sprain, contusion or broken bone is a result of a single injury whereas an overuse injury is the result of repeated activity that damages tissue over a period of time.

In the overuse syndrome, body tissue is being torn down faster than it can be regenerated. Swelling and tissue separation causes discomfort, but it also reduces tissue strength, predisposing a specific area to acute injury. Overuse leads to what we call a stress-riser. It takes less and less stress to cause an acute rupture or fracture.

There are four stages of the overuse syndrome:

Stage I — has inflammation and swelling, but no cellular separation.

Stage II — with repeated insult, tissue becomes fibrotic and thickened.

Stage III — there is tissue separation and may even be small tears.

Stage IV — there is complete disruption of the tissue, including tears of a greater than 1 cm in the rotator cuff. In this stage, x-rays often reveal calcification and osteophyte formation.

Stage I almost always responds to cessation of activity and conservative treatment.

There can be an overlap of Stage I and II, but you can consider it Stage II if conservative treatment has failed after a one year period.

The Author
DONALD L. AMES, M.D.
Dr. Ames, an orthopedic surgeon, is a sports medicine consultant with the Los Angeles Dodgers and National Athletic Health Institute, Vero Beach.

Stage III, particularly for the athlete, surgery is often the best solution.

Stage IV surgery offers the best solution, but few people return to highly competitive activity. It is often successful in relieving pain and allows the patients to return to activities of a less strenuous nature.

There are common situations often referred to as "Risk Factors" which may prove helpful in the prevention as well as the resolution of an overuse injury.

Training errors are generally due to an abrupt change in duration, intensity or frequency of training. Anatomical factors include flat feet, bowlegs or knock-knees, discrepancy in leg length or rotation of the legs, and any abnormal joint alignment. Pre-existing conditions such as old fractures, arthritis and many medical conditions (for example: arthritis), differences in relative strength or flexibility such as the strength of the quadricep muscles in relation to the hamstrings or the internal and external rotators of the shoulder are responsible for many sports related injuries.

External factors include improper equipment such as running shoes which provide inadequate shock absorbency and insufficient support in the hind foot and environmental factors such as hard running surfaces, as asphalt or concrete, which can increase the chances of microtrauma to the lower extremities.

Overuse injuries can also be classified as soft tissue, bony and soft tissue interface.

Stress fractures are generally the result of a change in intensity and duration of an activity, but they can also be the result of an external factor such as improper footwear.

Osteitis results in painful swelling of the periosteum of the bone and is one of the many causes of shin splints.

The bone soft tissue interface overuse can result in medial or lateral epicondylitis as occurs in tennis or golfers elbow where the flexors or extensors insert into the distal humerus.

Cross country skiers have learned that they can go faster by skating their skis. However, this leads to an increased stress over a period of time on the medial collateral ligament causing inflammation and swelling. There is a special situation which does not fit the above classification. The rotator cuff of the shoulders fits in a narrow space between two bones, the head of the humerus and the acromion process. Increased swelling or edema can lead to an abrasion process causing further tissue damage.

In the treatment of overuse syndrome, a careful history is necessary to eliminate the risk factors previously discussed. Conservative treatment consists of rest, ice, compression, and elevation, commonly referred to as "RICE." To use effectively, rest the injured area until all pain and swelling have subsided, use lots of ice, adequate compression, and elevation of the extremity should be above the level of the heart.

The non-steroidal anti-inflammatories, the most commonly used being aspirin, are more rewarding in Stages I and II. Controversy surrounds the use of steroids, although if judiciously used without repeated injections I have found them to be beneficial. You must avoid direct injections into a tendon. The same precautions should be used in the topically driven steroids. I do use 10% hydrocortisone cream, which can be prepared by your local pharmacist, driven into the tissue with either ultrasound or high voltage electrogalvanic stimulation. I prefer the latter as ultrasound causes an increase in deep heat and many times can often increase swelling and inflammation.

Surgery is indicated in Stages IV and V and sometimes in Stage II. There should be a 90% return of preinjury motion and strength before returning to strenuous activity. This can often be compared with the unaffected extremity and with clinical examination or with Cybex testing.

In summary, the overuse syndrome occurs over a period of time and can lead to stress-riser which can lead to an acute rupture or fracture. Treatment is generally conservative if recognized early, and one should always stop the activity and never exercise through pain. There should be a 90% return of function, motion and strength before returning to their activity.

● Dr. Ames, 777 37th Street, Suite A-101, Vero Beach 32960.

Athletic injuries caused by the new sport of windsurfing and a proposed set of preventive measures

Mutaz B. Habal, M.D., FRCS(C), FACS

ABSTRACT: The sport of windsurfing was introduced in the 1984 Olympics as the newest sport. This sport is spreading in almost every city in this country and abroad. In spite of the projected safety of the sport, injuries have been encountered. The purpose of this report is to describe and identify these injuries, so that the sportsman and the athlete can become aware of them. Preventive measures should be instituted to decrease the injuries encountered. The injuries reported are as drastic as death and as minor as sprains. A set of preventive measures is proposed, so that this delightful sport will be as safe as possible to those who enjoy it and for those who are thinking of getting involved with the sport.

The Author
MUTAZ B. HABAL, M.D., FRCS(C), FACS
Dr. Habal is with the Tampa Bay Craniofacial Center, Human Resource Institute, University of South Florida, Tampa.

The year 1984 marked the introduction of the new sport of windsurfing to the Olympics games in Los Angeles. The "new sport," actually 20 years in the making, is that of surfboard sailing. Originally it was called windsurfing and now is also referred to as boardsailing. This preliminary report will discuss a group of injuries encountered due to windsurfing accidents, and propose a set of protective measures for their avoidance. Since this sport is new there have not been any previous reports of such injuries in the medical literature, or of any major collective review of traumatic injuries due to windsurfing and their treatment. In this report, we stress the injury modes that are being encountered and their prevention. There are no details of surgical and medical treatment, since we presume that it will follow the prevailing standard of care for each injury by the specialist involved in the care of the patient.

Windsurfing or boardsailing • Before going into the details of the injury, a short note devoted to describing the equipment and its use will make it easy to understand the mode of injury and their avoidance. The equipment used in windsurfing is basically a surf and a sail. The boards vary in length from eight feet for advanced surfers, to 12 feet for beginners. The boards are 2'7" in width for beginners and 2 feet for advanced surfers. A universal joint in the center allows a mast 15 feet long (length also varies) to be rigged on a 5-8 feet boom. A sail that varies from 41 to 90 square feet in surface area is used. The universal joint, invented by California aeronautic engineer Hoyl Schwitzer, marks the basic key point for this unique sport. The universal joint makes all the equipment on the board movable, so they can be well controlled by the surfer.

The windsurfer stands on the center of the board with his feet on each side of the universal joint. The

surfer holds the boom in his hands for control of movement. The surfer's feet are in control of the surfboard, while his arms and torso are in control of the sail and steering of the board. Shifting positions of the mast forwards or backwards will allow the board to sail upwind or downwind. A sudden loss of coordination and balance by the windsurfer will cause the sail to fall into the water. The sail will anchor the board in the water, so there is no escape of the board with the wind or the waves, which is a good safety measure for the windsurfer. The larger the sail, the more force and power the surfer has to produce to keep the mast up, which also is in logarithmic parallel to the velocity of the wind, so more physical strength is needed by the surfer to go upwind than to go downwind.

The physics of boardsailing involve the basic aerodynamics of the force of wind transferred on the sail to move the board forward and to the sides. It is in a way similar to the force exerted on a wing of an airplane. The hydrodynamics is that of resistance of the surfboard in the water which is similar to that for all boats, concentrated on all dagger boards. The application of these two concepts was designed by computerized programming for each sailboard. New designs are being introduced continuously by using these concepts of resistance in water and power by the wind in the ultimate form of ideal designs of the sailboard.[1] In this paper, we refer to the standard surfboard and sail that are used by the majority of windsurfers, noting some variations used by advanced boardsurfers to produce more speed on the surface of the water.

Injuries ● When the sport was introduced, it was felt that no injuries would occur with windsurfing since any change in balance will cause the windsurfer to fall in the water. Then a major knee injury was encountered. It resulted in disruption of the stabilizing ligaments of the knee, due to change in the physical forces of the body and the feet. After a note was published in American Medical Association News[2] regarding this injury, windsurfing injuries were brought to our attention, and are tabulated in Table I. The injuries were more than we have anticipated.

The injuries that are discussed in detail are those requiring medical and/or surgical attention. There will not be any discussion of minor injuries encountered except in Table I listed as non-serious injuries. We do not discuss the mode of medical or surgical treatment for each injury, since the treatment modalities used follow the standard of care practiced by treating physician, and it is not the intent of this report to discuss the controversy related to each medical and/or surgical treatment.

1. Death due to drowning has been reported in one local newspaper. The death was probably due to hypothermia and the inability to cope with a change in weather conditions by the windsurfer.

2. Hypothermia, a serious problem, is seen particularly when the climate is moderate and the windsurfer is not accustomed to balancing on the board. The windsurfer falls in the water as he stands up again, followed by having total body exposure to the wind, which will produce a chill factor that will lower the core temperature of the surfer as heat loss by convection. Early symptoms of hypothermia include a tingling sensation in the hands and feet, followed by muscle weakness and fatigue. If unattended, cardiovascular collapse and death may occur. Many reported instances of hypothermia were noted, but none resulted in death except the one noted above. Usually, the experienced windsurfer when he is offshore protects himself with a wet or a dry suit. The beginner should stay close to shore, so he can be rescued easily if a problem does arise. All boardsurfers should have a wet or a dry suit on for protection, since the chill factor and loss of heat by convection is possible in cold or moderate climate.

3. Knee injuries are the most common problem (N=20). The knee is unprotected and the windsurfer does not recognize the weak point in the control between his feet on the board over the waves and his torso with his hands fixed to the boom on the sail to control the wind force. The knee in such a system is the weak point that is easily disrupted, particularly when the surfer is not aware of this problem. Knee injuries are usually in beginners and intermediate windsurfers, because they do not recognize the weakness points and try to do the impossible by accidentally stressing the weak points in the

Table I. — Wind Surfing Injuries N=153

Serious N=67	Nonserious N=86
Hypothermia	3
Head Trauma, Loss of Consciousness	4
Head and Neck Trauma	13
Eyebrow, Orbit Oculus Injury	1
Arm Fracture	3
Finger Fracture	2
Foot Trauma	8
Ankle Fracture	1
Knee Injury	20
Chest Wall Injury	2
Pneumothorax	1
Back Injury Disc Herniation)	4
Spine Fracture	2
Shark Encounter	2
Death	1
	67

*Non serious injuries include: skin cuts, contusions, skin burn, chemical burns, and all forms of sprains: ankle, shoulder, wrist, back and neck.

knee and by not paying attention to the differential of torso to knee forces during windsurfing. Medial collateral ligament rupture and anterior cruciate ligament disruption in combination are the most common problems encountered in windsurfing injuries. However, the lateral ligaments are also reported ruptured (N=4). The knee ligaments' disruption in this injury is dependent on the torque of the board, if it is in windward to leeward shift at the time of injury producing the sudden shift of the board and sail in opposing direction.

4. All head and neck injuries (N=18) are caused by the swing of the boom and/or the mast with a wind gust hitting the windsurfer in the face. This injury is usually encountered by intermediate to advanced boardsurfers. One broken neck from gusty high winds was reported. Mandibular fractures, fractured teeth and other fractures were also encountered. The windsurfer was trying to go upwind in a close reach as the wind shifts direction, resulting in loss of control of the sailing gear, with direct impact to the face and whiplash in the neck.

5. Other less common injuries included a fractured forearm which was encountered when a windsurfer fell down in shallow water, and an ankle ligament tear due to a sudden fall off the board in shallow water. Foot injuries were also noted. Chest wall injuries (N=3) as well were caused by the boom hitting the chest wall when it was placed on a lower location on the mast on high wind weather condition. Two shark injuries were reported. One windsurfer had to be treated by a team of doctors to put the soft tissue, bone, and vessels together, so he was able to resume normal function.[5,4] The second surfer recovered with a lost hand.

Sprains are common, but will not be discussed, since they are frequent in most sports, and physicians are aware of their treatment. Most of the time the athletes knew how to treat their sprains with local ace bandages for support, and avoidance of any further stress and trauma to that region until complete healing is achieved, without major medical consultation.

Preventive measures ● The preventive measures will be discussed in the order the injuries were listed, and then a general proposal for a universal preventive code will be outlined. This would be helpful when sending teams of physicians to windsurfing schools and competition sites for instructions and care of potential hazards related to the sport, so they will be aware of what to look for.

1. Drowning could be prevented by having windsurfers wear Coast Guard approved flotation harnesses. In case of sudden cold water exposure and ensuing hypothermia injury, or an escaping board if the sail is not leashed to the board, the windsurfer will be protected from drowning by the flotation harness. A few states have already instituted this safety measure as compulsory for all windsurfers. This should be a universal regulation. A variety of flotation harnesses with positive buoyancy are available for exclusive use by windsurfers. Windsurfers should never go alone into the high seas; they should be in groups of at least two or three.

2. Hypothermia can be prevented by wearing a wet or a dry suit in cold weather or moderate weather conditions for complete protection. This gear is already available and should be used by all windsurfers in the winter all around the world and in the summer in cold climate regions. Even in warm climate, the chill factor from the high winds can precipitate hypothermia.

3. Head and neck injuries can be prevented by a lightweight plastic protective helmet designed to protect the facial skeleton and cranium. Since such a device is not available, attention should be directed to designing such a helmet. The helmet used to protect the windsurfer's head from cold exposure should always be placed below the head gear, particularly in high winds. A team of professional athletes, physicians and representatives from industry can devise such a protective helmet, test it, and then implement its use after a compulsory regulation by the authorities is passed. This seems to be in great demand now.

4. A knee brace, similar to that used by other athletes should become available, particularly for sailing in high wind. Braces used by football players could be adapted for this use incorporating the brace in the dry or wet suit. Educating windsurfers on the cause of knee injuries should help them avoid this disabling problem.

5. Other injuries may not be as easily avoided and their prevention may not be by a protective gear but by proper education. These include fractured arms, ankle ligament tears and chest wall injuries.[5] As for shark bites, the best advice is common sense: avoid sailing in areas known to be inhabited by sharks; since sharks are nocturnal feeders, night windsurfing is not advisable.[6]

Thus a proposal for universal protection of boardsailors should include flotation harness, wet suit, head helmet, and knee braces. We propose that a committee to include industry, the leadership of windsurfers, and interested health professionals be formed and propose the standards for such protective gear for use by all windsurfers, whether beginners or professionals.

Unfortunately, well established athletes will probably be the most resistant. They may resent any restrictive measures they are not used to, particularly when they have been in the sport before such measures were implemented. However, such resistance is to be expected. The new athletes, on the other hand, will find the use of such protective measures from the start to be part of the sport, so they would not be as resistant to its use.[7]

Discussion • In the coming few years, with the wide dissemination and acceptance of the new sport of windsurfing, there will be many more windsurfers around the world. With this increase, more injuries will be encountered. If the proposed preventive measures are implemented, the sport should be safer. Perhaps by then, licensing will be needed to acquaint the windsurfer with the sport and the protective measures that should be used to make it safe.

These noted injuries are what have been reported to us and may represent a fraction of what may have actually been encountered. The best public health plan would be to implement the preventive measures during the sport's early phase when their implementation would be met with less resistance.

The use of any measures to prevent injuries cannot be overstressed. Because the sport is in its relative infancy, health providers should feel responsible for helping institute these measures and work closely with the industry on finalization of the protective gear for the head and knee; the other measures as the flotation harness and the wet suits are already available and in use.

These techniques of looking into prevention, utilized by any new sport before its inception are important.

In conclusion, we have reported a set of injuries caused by the sport of windsurfing and we have proposed some preventive measures. Hopefully, they will eventually be instituted as requirements for the sport. In spite of all these reported injuries, the sport of windsurfing is relatively safer and more enjoyable than other water sports for the amateur surfer and for the professionals. In the major metropolitan cities around the country and in cities situated around the lakes, windsurfing is becoming an integral part of the water mania. The treatment of the injuries noted follows the medical measures that have been proposed and used for each one. The future should provide a design of at least a protective helmet.

References

1. Drake, J.: The Physics of Boardsailing, Windsurf 14:60, 1984.
2. Habal, M.B.: Data Sought on Injuries Caused by Windsurfing, American Medical Association News, November 4:6, 1983.
3. Jones, A.: Brush With Death, Windrider 2:20-23, 1983.
4. Thomson, J. and Savadge, H.: Shark Attack, Windsurf 16:8-10, 1986.
5. Schweitzer, D.: Shark Attack Defense, Windrider 12:71, 1982.
6. Thomspon, D.: Whales, Let's Leave Them Alone, Windsurf 13:62, 1984.
7. Urris, K.C. and Anno, Kelby: Conditions Impact Board Sailing Injuries, Sailboard Racing, Windsurfing Newsletter, 1985.

• Dr. Habal, 801 West Buffalo Avenue, Tampa, 33603.

AVIS. FOR SAVINGS AND SERVICE AT YOUR CONVENTION.

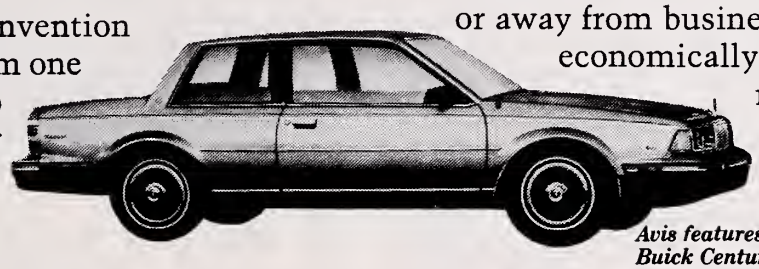
FMA 112th ANNUAL MEETING
SEPTEMBER 17 - 21, 1986
DIPLOMAT HOTEL - HOLLYWOOD, FLORIDA

Get all the quality and service of Avis at the convention.
At money-saving low rates just for you:

Car Group	Daily	Weekly
Subcompact like the GM Chevrolet Chevette	$20.95	$ 79.00
Compact like the GM Chevrolet Nova	24.95	99.00
Intermediate like the GM Pontiac Grand Am	26.95	119.00
Full Size 2-Door like the GM Olds Cutlass Supreme	28.95	139.00
Full Size 4-Door like the GM Pontiac Bonneville	31.95	159.00

Rates are good from one week before to one week after the convention.

These special convention rates are good from one week before to one week after your convention.



Avis helps you get down to business — or away from business — quickly and economically. So call today to reserve your Avis convention car:

1-800-331-1600

Avis features GM cars. Buick Century.

And be sure to mention your Avis Worldwide Discount number to get your special convention savings:

A/W022407

Present this I.D. card when you pick up your car.

TO RESERVE YOUR AVIS CAR
CALL 1-800-331-1600

When you reserve your car, please give your AWD number (shown below) to get your special savings. And present this card when you rent your car.

Florida Medical Association

Your signature

A/W022407

Rates are nondiscountable. Rates only available at participating U.S. locations. Cars subject to availablility. One-way service fee will apply, when cars are not returned to renting location. Renter must meet standard Avis age, driver and credit requirements. Refueling service charges, taxes, optional CDW, PAI and PEP are not included.

TRYING HARDER MAKES AVIS SECOND TO NONE.®

AVIS

©1984 Avis Rent A Car System, Inc., Avis®



Health Care At Its Best: Air Force Medicine

Air Force medicine is one of our best benefits, and, with your help, we'll keep it that way. The Air Force needs physicians such as you to become members of our health care team.

Most administrative responsibilities are in the hands of others, giving our physicians the time to give their full attention to the patients' needs. Our hospitals are staffed with dedicated, competent professionals.

You'll find you will have time for your family, and to keep abreast of the latest methods and technologies that you don't have time for now. We also offer unlimited professional development and financial security.

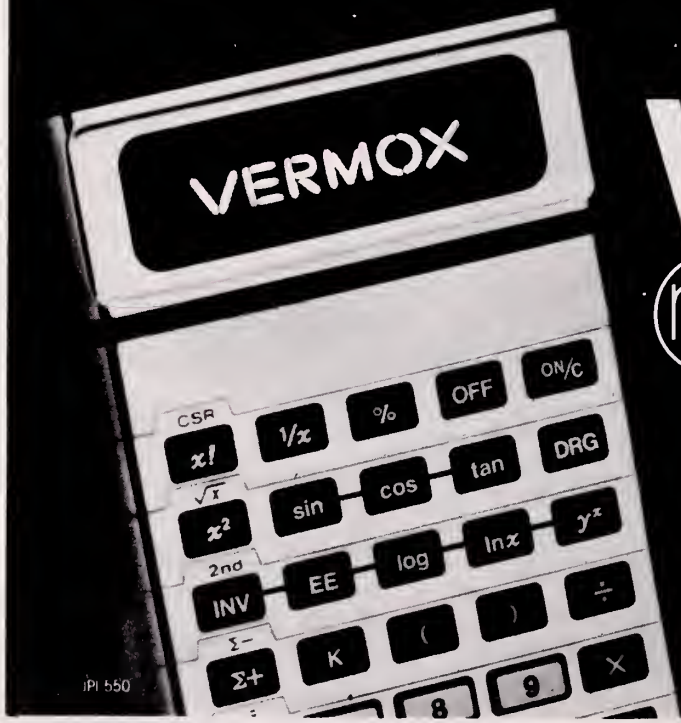
If you're considering a change, consider Air Force medicine. To find out more about Air Force medicine, contact your nearest Air Force recruiter. Experience health care at its best.

Contact: Medical Recruiter, 305/494-2728 or 305/494-2730. An equal opportunity employer.

AIR FORCE

A great way of life.

No need for dosage calculations...



VERMOX®

(mebendazole)

CHEWABLE TABLETS

JANSSEN PHARMACEUTICA

Piscataway, NJ 08854 3998

* Janssen Pharmaceutica Inc. 1985

SPECIAL ARTICLE

Prison health care: problems and alternatives in delivery of health care to the incarcerated — Part II

Jacqueline M. Moore, R.N., M.S.N.

Constitutional issues regarding correctional health care • That it is constitutionally permissible for a state to imprison those convicted of a criminal offense or those charged but not convicted who are detained and awaiting trial is not disputed. The state's duty to protect its citizens from criminal offenders and the recognition that prisoners retain some constitutional rights during incarceration have made it necessary for the Supreme Court to differentiate between the rights afforded free citizens and those retained by incarceration. Although prisoners are said to retain all rights not specifically taken from them by the nature of confinement, the opposite is true.[20] For too many prisoners, the right to a minimum standard of health care is unrealized. Consequently, without an enforceable fundamental right to protection of health and safety, a prisoner's other rights are meaningless. It is the intent of this section of the paper to discuss the consitutional issues and legal developments which have helped to formulate current correctional health care policy.

Historical perspective • The constitutional law of correctional health care is relatively new and rapidly evolving. The prisoners' rights movement grew directly out of the civil rights and civil liberties movements when civil rights organizations turned to the courts to challenge what were essentially legal barriers to equality and liberty.[21] Since there were relatively few prisoner advocate groups in the early 60's, much of the preliminary work performed by civil rights movements left the prisons unaffected.

In order to understand prison health care litigation, it is important to understand its legal basis. The policy regarding correctional health care stems from the constitutional right guaranteed by the Eighth Amendment to the United States Constitution which states, "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted." The Eighth Amendment rests upon fundamental considerations of human decency. It has been held to contain a "basis prohibition against inhumane treatment" and its basic underlying concept is nothing less than "the dignity of man."

Historically, the Eighth Amendment's ban on cruel and unusual punishment was aimed at a recurrence of torture common in England and colonial America such as disemboweling and decapitation. During the 19th century these punishments were no longer imposed and this provision was thought to be virtually obsolete. Today this Amendment has been applied to the use of physical force by correctional personnel on inmates for purposes of retaliation or punishment. Corporal punishment such as "beatings, whipping, use of leg straps, teeter boards, tucker telephones, exposure to extreme heat or cold, standing on the line for excessive periods of time, and deprivation of sufficient light, ventilation, food or exercise has been widely condemned by the courts and are almost certain to subject the jail personnel to legal liability suits.[22] In recent years the provisions of the Eighth Amendment have been further expanded to include the right to medical treatment, albeit the progress has been slow. While barriers to improvement of correctional health care are numerous, the reason most frequently cited is: the de facto "hands-off" attitude taken toward prisoners by the courts which has been universally accepted for many decades.

"Hands-off" attitude adopted by the courts • Zalman reports that a century ago individuals incarcerated in penal institutions had virtually no rights.[23] He states that prisoners were considered "slaves of the State and entitled only to the rights granted to them by the basic

The Author
JACQUELINE M. MOORE, R.N., M.S.N.
Ms. Moore is with Prison Health Services, Inc., Wilmington, Delaware.

humanity and whims of their jailors." Until recently, this philosophy was maintained by the judicial system and the courts clung to a "hands-off" doctrine which interpreted the realm of prison administration as beyond their jurisdiction to review. The inevitable result of this "hands-off" policy adopted by the courts was to grant prison administrators broad discretionary powers in the way they cared for and treated their charges.[1] For the most part, prisoner cries regarding civil rights deprivations went unheard and prisoners were virtually barred from obtaining redress for anything but the most extreme deprivation of medical care.

In addition to the concept of separation of powers, the courts also reasoned that they lacked the necessary expertise in penology to determine whether actions of prison officials were justified or not and stated a further reluctance to interfere based on the notion that such intervention might subvert prison discipline.[24] Moreover, the courts feared that if they interfered in prison administration a constitutional tort of medical malpractice would be created; thus, giving prisoners a federal remedy which far exceeds those available to the ordinary citizen in medical malpractice suits.[25]

The effect of judicial reluctance to interfere in internal prison affairs was to grant relief only where a petitioner could show that medical treatment or lack of it amounted to cruel and unusual punishment of such magnitude as to "shock the conscience of the court. . ."[23] or "barbarous acts of such obvious and intentional mistreatment" and conduct so grossly inadequate or excessive as to be intolerable to fundamental fairness.[15] In summary, the principal tests applied under the Eighth Amendment were whether the punishment shocks the general conscience of a civilized society; whether the punishment is unnecessarily cruel; and whether the punishment goes beyond legitimate penal aims.[26]

Toward developing constitutional standards for prison health care ● The inadequacy of a barbarous conduct standard for claims of deprivation of medical treatment readily became apparent and generated increased pressures for reformation. Criticisms of the standard revolved around two major issues: first, the standard did not address the frequent complaints of denial of medical care for serious physical ailments that were not life threatening and, second, the barbarous conduct standard failed to cover the increased allegations made by inmates of misconduct by health personnel.[15]

Prisoners began complaining in court not only of deprivations resulting in paralysis, brain damage, and death, but also of inattention to less threatening but still serious infirmities that needed medical attention. While these medical deprivations were matters of concern to the courts, the outcomes were not grossly shocking to themselves and thus were not addressed under the barbarous conduct standard.

Given the inadequacy of the barbarous conduct standard by which to interpret prisoners' right violations, the judiciary began to search for a broader interpretaion for determining whether a constitutional violation had occurred. During the early 1970s, the federal courts in particular began to overcome their previous reluctance to intervene in matters regarding the internal administration of correctional facilities and began to adopt phrases such as "abuse of," "deprivation of basic medical treatment," and "deliberate indifference to inmate's requests for essential medical treatment." Emerging case law at all levels of government began to dictate that basic requirements of adequate health care must be met.

Newman v. Alabama ● The first major federal civil rights action devoted entirely to medical care was *Newman v. Alabama*, 503 F 2D, 1320 (CA 5, 75). In October 1972 a U.S. District Court found that the entire correctional system in Alabama had violated the Eighth and Fourteenth Amendment rights of the inmates by failing to provide them with adequate and sufficient medical care. The court placed the state's correctional agency under injuction and demanded immediate remedies for all existing deficiencies. Budgetary constraints were deemed to be an insufficient defense for failing to provide care.

Following on the heels of *Newman*, a host of other cases were decided in favor of specific rights of a particular inmate. While many federal court precedents were established during this era, it should be noted that court decrees are only binding on the specific litigants involved. Thus, in the absence of specific federal legislation making prisoners' rights to health care binding in all states, there was no assurance that correctional administrators would adhere to current legal trends.

It was clear, however, that the federal courts no longer felt that the Eighth Amendment was obsolete and now interpreted it to include the provision of basic medical care for the incarcerated. At first, different courts used different standards for determining when a constitutional violation had occurred. The one guiding principle in this search for a more appropriate legal standard was the concern that the standard not be so expansive as to encompass mere malpractice claims. Therefore, the end result of these various judicial decisions was an inconsistency in interpretation which continued until 1976 when a prisoner's claim for medical care reached the Supreme Court in *Estelle v. Gamble.*

Estelle v. Gamble ● In *Estelle v. Gamble*, a Texas prisoner, J.W. Gamble, complained that the prison custodial staff and medical director failed to provide him with adequate care following a back injury. Gamble did not allege that he was denied medical care altogether but that the medical care he received was

inadequate. According to Gamble's complaint, he had received 17 examinations in all during the time covered by the complaint. Gamble's complaint was that he had not received x-rays and other diagnostic tests, had not received prescribed medicine for pain, and was periodically refused attendance at sick call. He stated that this series of events violated his constitutional rights.

In its evaluation of the case, the Supreme Court considered the obligation of the government to provide care for an incarcerated individual who has no alternative source of treatment and is otherwise incapable of providing care for himself. The Court concluded that the pain and suffering which may result from a denial of medical care were found to have no legitimate penology purpose and to be "inconsistent with contemporary standards of decency" (429 US at 103). Thus, the Court ruled that the proper standard to be applied in considering this and other prisoners' medical cases was whether the action or nonaction of prison officials showed "deliberate indifference to the serious medical needs of prisoners." "Deliberate indifference" was defined as the "wanton infliction of unnecessary pain which can be manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally interfering with the treatment once prescribed." (*Estelle v. Gamble*, 429 US at 104-5). In *Estelle v. Gamble*, the court concluded that the complaint was predicated on a failure to provide additional diagnostic tests and alleged it as a claim of medical malpractice against the prison doctor (429 US at 107) and not a violation of constitutional rights.

Through *Estelle v. Gamble*, the Supreme Court established a uniform standard of "deliberate indifference" which must be applied to all courts dealing with prison medical care claims. While "deliberate indifference" has replaced the earlier standard of "barbarous acts which shock the conscience," the new standard is no more directive in reaching results. This is because the Court concluded that the action in *Estelle* averred only medical malpractice without offering any guidance as to how it reached its conclusion. Consequently, when judicial decisions are not communicated clearly to those responsible for their implementation, the opinions can often be misinterpreted and misunderstood.[27] Thus, without sufficient guidelines and meanings for the application of the new standard, a wide variation in interpretation has been reached by judges in lower courts.[15,25,28]

Current judicial trends • The judicial attitude has changed drastically from the de facto "hands-off" philosophy of the past; courts are now willing to intervene somewhat in correctional health. While judicial definitions regarding the rights of prisoners are only beginning to evolve, they represent the beginning of a "standard of decency in a modern 'society.'"[29]

Considering the time consumed by various court litigations and intensive efforts on the part of all parties to bring about even slow improvement, one can understand why many people, including Supreme Court Justices, believe that the judiciary is not the institution best suited to improve inadequate health care.[30] A cost-benefit analysis of recent court cases would surely reveal that litigation achieves only incremental improvement at enormous cost and by insufficient means.

The deliberate indifference standard provided by the Supreme Court in *Estelle v. Gamble* is cumbersome in redressing individual claims of inadequate medical treatment. The *Estelle* decision clearly established an inmate's "right to health care" but left unanswered such questions as "What standard of care is the inmate entitled to?" "Must every medical need be met?" "What about elective medical care?"[22] Consequently the application of this standard has been stretched to include all claims pertaining to prisoners' medical needs rather than those involving inadequate medical treatment.

Given the variety of medical needs of inmates, it is not surprising that there is a wide diversity of judicial decisions in factually similar cases. The concept underlying the "deliberate indifference" standard is that "deliberate or intentional" failure to treat medical needs must be proved by the inmate in order to avoid the consitutional tort of medical malpractice. The difficulty lies in determining what part of the behavior on the part of the prison staff or medical team is "deliberate" or "callous."

Additional reasons for the diversity found in the analysis of the court decisions may be due to the fact that prison health care litigation is a relatively new area of law and there is not a wide body of prior case law covering similar facts on which a judge can rely. Additionally, since the deliberate indifference standard has such a broad interpretation, a judge's subjective reaction to the facts may play a larger role in the outcome than is true in areas of law with clearly defined standards.[28]

Both the nature of the plaintiff and type of relief sought may also affect the outcome of a case. Courts have taken a more active approach in remedying future violations opposed to past wrongs. Therefore, they are more willing to impose a judicial mandate on prison administration regarding medical staffing patterns and physical facilities as opposed to granting monetary awards. Consequently, when money damages are sought, a court may require proof of a specific intent to harm the inmate before making the prison official liable.[28] The trend of recent decisions has been toward a position that prisoners have a constitutional right to adequate medical treatment. From the outset, it should be noted that the courts have tended to treat the terms "adequate" and "reasonable" as equivalent and have taken a negative approach by what is considered to be inadequate or

unreasonable medical care.[22]

A prisoner does not lose his right to health care because of incarceration. The Eighth Amendment establishes the obligation of prison officials to provide medical care for those incarcerated in their prisons and jails. However, for many inmates these rights are still illusory since implementation and enforcement rests primarily in the hands of prison officials who often continue to fight for the status quo.

Alternative models of health care delivery • Within the last decade, many correctional administrators have been faced with court orders to upgrade medical services. Thus, as a result of recent judicial decisions, prison officials began to evaluate the level of health care provided at their institutions and to investigate innovative alternative approaches to health care delivery.

There are basically three methods of health care delivery utilized to provide health care in penal institutions. They are an in-house service managed by the warden or jail commander, care provided by the public health department or local hospital, and care provided by a local contractual firm which parallels the HMO concept.[18]

In-house services under direction of warden • Health care services in prisons are for the most part provided under the direction of the warden who is also responsible for the custody of the incarcerated. Problems with this arrangement stem from the fundamentally different and often conflicting goals that exist between security and the health care providers. For example, if correctional staffing is down, then outside medical trips may be cancelled or delayed by nonmedical staff. Additionally, because resource allocation is controlled, requests for health care are often in a relatively weak position as compared to requests that will serve the basic custodial purpose.

Second, this model of health care is extremely fragmented, uncoordinated, and expensive. Each service component, hospital, physician, nurse, dentist, is purchased separately from different providers. Under this type of arrangement, each vendor has a financial incentive to maximize the use of his services, and to increase his revenues regardless of correctional budgeting constraints or population health care needs. The warden faced with a legion of problems within his own institution is hard pressed to find ample time to address the organization and delivery of a complex health care system. The results are a patch work of services which has very little medical communication or coordination between the providers.

In this model there is frequently a heavy reliance on the emergency room for services, which is both an expensive and inefficient approach to health care delivery. It is not uncommon to find hospital stays of 22 days or more for a procedure that normally requires three or four days. When one considers the expense of hospital rooms plus 24 hour guard coverage, this model's health care budget becomes crippled in a hurry.

Staff recruitment is also problematic under this type of arrangement. Jails are located in isolated rural areas where professionals routinely choose not to live. Salaries are frequently poor and not adequate to attract young, energetic physicians. Wardens, unfamiliar with adequate credentialing procedures, unknowingly employ impaired or incompetent doctors. Conversely, in this model, it is also possible to find a professional who has manipulated the system to his advantage. For example, a physician may be paid an annual salary of $95,000 for less than 20 hours of clinical work per week. Staff ratios are also poorly managed. There may be few medical staff in this system and they may consist primarily of EMTs or LPNs who are also poorly paid.

Thus, the basic deficiencies associated with this model are: conflicting attitudes among correctional staff which may hinder the provision of health care, lack of a comprehensive or coordinated plan of care, lack of both clinical and financial acountability, and difficulties in recruiting qualified staff.

Local hospitals or public health departments • A growing number of county jails now rely on health departments or local hospitals to provide care for their detainees. While these arrangements have assisted the local jails in obtaining needed services, they demonstrated a poor track record in their ability to control health care costs. This is because there is frequently an overutilization of services which can be a significant cause of inflation in medical costs, not to mention a conflict of interest which exists on the hospitals' part in the provision of laboratory and radiological procedures. An open-ended system of health care financing naturally invites uncontrolled growth and expenditures.[18] Additionally, hospitals have routinely demonstrated a poor track record in their ability to control health care costs. Semiprivate room rates have more than tripled since 1965 and medical care has routinely occupied 10% of the consumer price index.[31]

The second disadvantage of this model is a geographical problem. Jails exist in rural areas; hospitals and health departments are not there. Additionally, hospitals and public health departments may not have the interest, experience, or capability to provide correctional health care.[32] Correctional health care may not always be a priority of the hospital or health department and may be overlooked during staffing shortages.

Except in special circumstances, the government, in the form of public health departments, is not well suited to deliver health care services to this population. Although this is a debatable point, it would appear that the combination of political, civil service,

union, and bureaucratic constraints make the government an extremely cumbersome vehicle for delivering high quality health services. The private sector has more flexibility to organize and manage a delivery system in a timely manner. Finally, in the hospital model, the correctional institution is still liable for lawsuits regarding the provision of health care.

Contractual health care • Contracting for inmate health care is a relatively new phenomenon which was begun in the early 1970s. Largely as a result of court decisions that mandated higher levels of health care for prisons and jails, several correctional facilities have turned to the private sector to provide medical care. Since the 1970s, outside contractors have supplied virtually full medical care and management services to jails in New York, Baltimore, San Francisco, Kansas City, and Chicago, and to state systems in Maryland, Alabama, Arkansas, Delaware, Iowa and Florida.

The principal design characteristics employed in this model closely resemble those employed in a Health Maintenance Organization (HMO). Financing of the correctional facility health program in this model is frequently done on a capitation basis. In capitation financing, the provision of a specified group of services is provided for a fixed monthly or annual fee regardless of services' utilization.[33] The total annual charge to a contracting prison facility is based on the inmate population of the facility. The contractor is responsible for all costs associated with providing independent health care providers, thus enabling the correctional facility to establish an annual budget with assurance that budgeted expenses will not be exceeded. A capitation financing approach to correctional health care provides obvious incentives to the managers of these organizations to deliver health care to detainees as economically and as efficiently as possible. The outcome is frequently a reorganization of the health care delivery system, resulting in lower hospitalization rates, decreased use of emergency rooms, more care provided on-site or on an outpatient basis, and lower total health care costs. The correctional facility benefits from this approach in that it requires no government regulations, legislation or emergency funding for the provisions of health care to detainees.

Once the parties sign the contract, the management firm sets about delivering three major products: recruitment, management, and accountability. Generally, the contractual firm has an advantage in offering levels of compensation and an identity with a health care organization that is not available in the other models. The company's resources and national reputation as professional health care managers give it a distinct recruitment advantage over the state's or county's past efforts. It can offer attractive career patterns, geographic mobility, timely financial incentives based on performance versus seniority, and the provision of a mandatory continuing education program.

The programs designed specialize in correctional health care and are designed to upgrade health services. Generally, they feature planned approaches to the clinical management of the problems associated with drug and alcohol detoxification and there are protocols for the treatment of common inmate health complaints. With this model, there has been reported a notable increase and consistency in hours of staff coverage,[34] which increases the inmate's accessibility to health care, more comprehensive intake examinations, improved follow up of patients with health problems, and a better record keeping system.[32] Additionally, contract groups have the ability to institute strict financial control on accountability. There is frequently a decrease in outside referrals by convincing specialists to make site visits inside the jail and a reduction in inpatient length of stay. Contractors can institute strategic and operational planning from the corporation as well as the institutional viewpoint. They have the ability to apply business principles to the delivery of health care and can take advantage of economics of scale when purchasing equipment, medical supplies, and laboratory services. Cost analysis has shown that the contractor is able to deliver a higher quantity of health care at a lower cost per inmate.[17]

The fear of most prison officials is that the private contractor will reduce services to inmates in order to reduce costs and increase profits. This fear is unfounded. It is generally espoused by most contractors that the potential risk of under service by the contractor is frequently offset by the threat that the correctional institution can and will opt not to renew the contract.

The primary reason for the success of contractual health care firms has been lawsuits and the body of case law that is evolving which guarantees inmates the right to medical care. Medical care is seen by the courts as a basic human right and the quality of health care provided to the incarcerated population is judged against current community standards. These legal inducements along with a shortage of willing professionals, isolated rural areas, plus the spiraling cost of medical care have created a market for private medical care companies.

One of their most significant selling points is that they will assume responsibility for any liability arising from the administration or delivery of health services, thereby absolving the prison from such responsibility. Prisons are sued constantly by inmates for claims of improper medical care. The contractual firm eliminates the responsibility of the prison by defending all lawsuits and paying all associated legal costs and settlements. Traditionally, contractual firms report that the number of inmate lawsuits has historically declined immediately after a firm implements its health care system.

In many cases, the contractor has become a powerful constituent for prison health care. By insisting on certain conditions in their contract, they have allowed the health care system to become independent and to avoid co-optation by the prison's dominant security interests. Additionally, many prison officials view the management of health care as a burden and are very receptive to giving it to independent providers.

While it is true that contract health care companies have improved data gathering, management, and recruiting, ultimately their worth comes down to one question: how good is their health care? Little objective data exist on the quality of prison health services provided contractually because routine indicators of quality are difficult to evaluate in the correctional institutions. Most evaluation studies of correctional health programs focus on structural aspects of the program with little attention to process or outcomes. The assumption underlying this approach is that if facilities, staff, and equipment reach specified standards, then medical care will be good.

While there are many studies advocating the effectiveness of Health Maintenance Organizations,[30] only two relate this concept to a correctional environment. Freeman et al reported that after implementation of a contractual service in a Baltimore City Jail, the program was associated with a decreased utilization of men's sick call, increased duration of patient encounters, and a decrease in the number of prescribed drugs.[36] The investigators concluded that the system allowed for a reorganization of the services and more humane and professional encounters to exist between providers and patients.

Mala et al reported a cost savings associated with the use of contractual services in Alaska.[37] There were significant savings reported in the areas of medications, consultations, transportation costs, physician time, hospital services, an increase in the early identification of client problems, and the practice of preventive medicine.

In summary, the contractual model for prison health care has distinct advantages in the provision of medical care. Recruitment of staff, formulation of a medical program, and creation of appropriate conditions for the delivery of medical care are facilitated by this type of arrangement. Empirical results attesting to improved quality or efficiency have yet to be demonstrated by this model.

Conclusion ● It is obvious from this extensive review of the published literature as well as my own personal experience in the correctional field that a significant number of jails lack health programs and that those that do exist are overutilized, obsolete, unsafe, and unsatisfactory. Economic as well as attitudinal barriers have prohibited the provision of health care to this population.

The issues involved in the provision of prison health care are essentially political and ultimately must be addressed by the legislative branch of the government. Many state legislatures, faced with the potential of class action liability suits, are taking a hard look at fund alloction and the delivery of health services to the incarcerated.

An important first step in planning and financing these services is the acquisition of basic clinical data to determine health problems and utilization rates. In order to design an effective program, one must be aware of organizational restraints, recruitment problems, and security issues. This paper has been a review of these issues and a discussion of the models of health care delivery currently available.

Just as in any movement for social change, litigation can only be the beginning of or catalyst for reform. The issues of inadequate health care must ultimately be addressed by society which will effect legislative changes and the resources necessary to sustain them. In this country, we have been through a period of many years of penal reform without substantial changes. Whether a meaningful change can be made in the health care delivery for prisoners is a challenge facing not only health care providers but all society. For society to ignore this challenge would indeed prove that a prisoner is a "slave of the State."

Part I of this article appeared in the July 1986 issue of the *JFMA*.

References

Available upon request.

● Ms. Moore, Prison Health Services, Inc., 1200 Philadelphia Pike, Wilmington, Delaware 19809.

On the brink of disaster — the divergence of American culture and American medicine

H. Frank Farmer Jr., M.D., Ph.D.

Throughout the history of medicine in America there have been several distinct and identifiable periods in which physicians and medicine have been at the peak of positive public opinion with all the good feelings and adulation that go with this status. Conversely, there have been times when we have been viewed with disdain and mistrust by the patients we serve. During these latter times, medicine seemed to teeter on the edge of disintegration and came perilously close to being dismantled and rebuilt to the expectations and conformities of outside influences. If this had happened, medicine as we know it today might not exist. It would be in an entirely different format, unrecognizable and bearing little resemblance to its present form. Fortunately, when medicine was at these ebbs of public opinion, forces were present to bring us out of the depths of public scorn and criticism and raise our prestige. While at the zenith of these cyclic episodes, we were always blessed with the protective cloak of public approval.

It is interesting to study those periods when we were alternatively at the zenith and nadir of public opinion and try to discern and analyze those factors which led to such divergent positions. Over our 300-year history it is relatively easy to study the trends, as unfortunately there have only been several identifiable periods in which physicians and medicine were at the top of public approval. Generally, the medical profession of America has only been met with approval during the Colonial Period (late seventeenth century to the late eighteenth century), early twentieth century (1910-1930), and post-World War II (1945-1960's). In all other times we have either been viewed as indifferent, dangerous, incompetent, or greedy to the point of endangering the economic security of the country. If there have been far more years that we have been unfavorably viewed than favorably, are there any common threads that we may look for to help us in our current situation? What are the common factors that led medicine to this trough of public opinion or, perhaps more importantly, what led us from the depths of public opinion to the zenith to again enjoy the approval and adulation of the American public?

Beginning with colonial times it is obvious that it was not the quality of medical care that stood the American profession in good stead. Medicine was largely confined to crude setting of bones, amputations and ineffective methods of medical treatment. However, what the colonial medical profession lacked in scientific approaches was made up for by a sense of public service and leadership that saw the medical profession contribute a disproportionate share of its members to the halls of the Continental Congress, the debates on the Declaration of Independence and the battlefields of the Revolutionary War. In essence, physicians were not revered because of their scientific ability, which was scanty, but because of their activities as leaders and statesmen. In looking at this through the eyes of the values of colonial society, it is fairly easy to see why this was so. Scientific methods were not yet appreciated. In fact, science was largely suspect. Science, as it was known then, was just coming out of a period of mystery and intrigue and had a hefty mixture of magic and hucksterism. Science was not yet science and the values appreciated were the values of individualism, self-reliance and an ability to face hardship and persevere.

The Author
H. FRANK FARMER JR., M.D., Ph.D.
Dr. Farmer, Historical Editor of The Journal, practices internal medicine in New Smyrna Beach.

The doctor as a public servant fit this mold and would occupy one of the more exalted and prestigious positions . The lack of emphasis on the ability of the medical profession to perform scientifically would linger on into the nineteenth century and would only be eroded by events from the early 1800's to the beginning of the twentieth century. Some cracks in this view of medicine began to appear in the 1830's as the Industrial Revolution swept the world. From this period to around 1910, the medical profession would begin to slowly slide into a nadir of poor public opinion. While an industrialized America began to be shaped, the medical profession would not follow this change of American culture. There were many medical discoveries throughout the world during these years, but the facts are that not many of these discoveries made a difference in the medical care of Americans. The longevity rate did not appreciably change and mortality continued largely unabated and Americans began to equate quality medical care with Europe and the European methods, such as formal education and clinical training for physicians. As the American frontier was shrinking, the Americans began to turn away from acceptance and approval of doctors as being people of worth because of their participation in public affairs. As the values of American society changed, the attitude towards doctors also changed. It was an attitude that doctors should be doctors, and competent doctors at that. Concurrent with the acceptance of scientific principles was the fact that during the 1800's fewer and fewer doctors were recognized public servants. Doctors began to be more like doctors than public servants, but the only problem was that while giving up one role and assuming another, they did so with inferior tools.

As the values of American society changed, the attitude towards doctors also changed. It was an attitude that doctors should be doctors, and competent doctors at that.

While advances in scientific techniques swirled around the western world, American medicine did not make any appreciable advances until around the turn of the twentieth century. As a result, by the 1860's, doctors had reached a low point in the eyes of the public. Throughout the last part of the nineteenth century, physicians in America continued to be poorly trained with very little emphasis on formal curriculum and training. Physicians still were produced in great number by the apprentice method, by which prospective doctors attached themselves to a practicing physician and learned the tools of the trade. There were a few medical schools which were beginning to have a structured curricula and the beginnings of a scientific approach to the making of a doctor. However, many of these medical schools were just as inferior as the apprentice system with no requirements for admissions, very little clinical training and a curriculum which may or may not provide an adequate medical foundation. As a result, American doctors were far behind their European counterparts as universities in Scotland, England and other countries turned to a more structured approach with internships, clinical training and a formal curriculum.

The American public knew the difference between American medicine and European medicine with the results that those who could afford it wanted to be treated by those doctors who had been educated and trained in the European medical centers. Those who could not afford this choice or lived in a geographic area which did not offer this had to be content with the American product. Obviously, the great majority of Americans had to settle for the inferior scientific product, but they did not like it and the collective opinion of Americans toward the medical profession by 1900 was that doctors were necessary evils in most cases.

Between 1900 and 1920, the medical profession would begin a climb back to the zenith of public approval. This return to a favored status was a result of several things, but collectively it can be said that it was because the medical profession accepted the scientific method and incorporated it into its training and practice. This was what Americans wanted at this particular time of our evolution. The atmosphere of the country helped lead to these changes. America was in a reforming mood, which sputtered and burned intermittently in the 1880's and 1890's, but which burst into full flame in the early 1900's. This reform movement involved every facet of American life from economic to social ills and medicine was swept up in the momentum, fortunately for the betterment of American medicine. The reformers would pressure the government to enact laws which ended the unsanitary conditions in the meat packing industry and regulate and establish standards for the production and sale of pharmaceuticals among other things. The embodiment of the turn to scientific principles was the *Flexner Report* of 1910, which condemned the system of medical education which existed in the United States by evaluating every medical school in this country and Canada. The results of the survey were devastating as they showed that many so-called medical schools were inadequate in teaching students to be physicians. Many institutions were medical schools in name only. As a result of the *Flexner Report*, many medical schools closed and those that remained open strengthened and improved their curricula. This was the culmination of the scientific approach to medical education. As part of the general movement to establish standards for physicians, many states began to pass laws for licensure including

requirements for attendance at an accredited medical school with sufficient time for clinical training with internships and residencies.

As the reform movement spread across America, the medical profession was swept along and restructured. In retrospect it was largely outside forces nurtured by the American culture which paved the way and brought medicine from the depths of the late 1800's.

From 1911 to around 1930 medicine enjoyed a relatively popular niche in American society. This position began to erode in the late 1920's and rather precipitously headed once again to another nadir of poor public opinion by the 1930's. The reasons for this are fairly well discerned. After medical education was put on a sound footing, the hue and aura associated with the reform movement began to slowly wear off. By World War I it was an accomplished fact that doctors were trained in the scientific approach. However, there were not many changes in American medicine, at least not those which the public could perceive. Hospitals did not exist in great numbers. Insulin was discovered in 1921 but did not have a significant effect for many years. Penicillin was grown in a laboratory, but no significant production of the drug would begin until the 1940's. Even more important, the Depression of the 1930's dragged medicine into the despair of hopelessness and lethargy that engulfed the rest of society. Physicians were on street corners selling apples, with their families going hungry along with the rest of America. Doctors were not changing things for the better. No new medical discoveries helped Americans to fight their way out of the Depression. In essence, medicine was at a low ebb with the rest of society. Ironically, what had rescued American medicine in the early twentieth century, an acceptance of science, had very little appeal for Americans in 1935 as they desperately tried to survive the dark days of the Depression. Adulation of the medical profession was the last thing on American minds as they did not have enough money to buy food, let alone pay for the medical care which really offered very little different from the medical care of 1910. The fact that the medical profession had incorporated scientific principles into its teaching of doctors had lost its major appeal by the mid-1930's.

This should have sounded a warning bell for watchers of the medical profession. Again, in retrospect it appears crystal-clear that the attitude of the American public to medicine was going to correlate with the economics of society. The cost of medicine was not high in the 1930's, but regardless of its overall cost, it was high in comparison to other things, as this cost often had to be traded off with the necessities of life such as food. Therefore, it appears that there were at least two factors in the decline of the prestige of medicine at this time. The first is that in relative terms, medical care was expensive as people had to forego some of the necessities of life to pay for that medical care. The second is that medicine was not able to point to any significant advance on its part that was improving the quality of life at that time.

Suddenly, in 1941, American medicine once again began a climb from the depths of poor public opinion. However, this was a period in which we climbed from the nadir to the zenith of public acceptance in a few short years. From 1941 to 1950, the medical profession would be on a meteoric ride to the approval of American society and once again gain the status of a "favored" profession. This approval of the medical profession would continue until the early 1960's when we would once again begin to decline in public opinion. By the late 1970's we were rock bottom in terms of public approval and acceptance.

What happened in the space of 30 years to explain this phenomenon? The impetus to rescue medicine from the 1930's was World War II which would forever change the face of American medicine. World War II saw government put its forces into medicine with millions of dollars going to research to speed up production of penicillin and other antibiotics, new methods of blood banking and surgical techniques refined on the battlefields. Suddenly, medicine was infused with a whole new generation of technology; in addition, it defined and improved methods of delivery of health care to Americans as the Veterans Administration's hospitals cared for thousands of wounded Americans. The intrusion of money into the medical care system of the country continued after the war with the Hill-Burton Act providing financial incentives for thousands of hospitals to be built across the country. Suddenly, Americans began to appreciate the medical profession again. People now could be treated and cured as opposed to only a few years before when they died with infections, lack of hospital facilities and antiquated surgical techniques. Just as important as the new technology was the fact that it was not prohibitively expensive. The public had what it wanted: a gigantic step forward created by medical technology which would benefit the average citizen and offer hope for injuries and diseases that were fatal only a few years previously. The medical profession got the credit for this startling change although in reality it had largely been external forces which had brought about the changes. Nonetheless, the medical profession accepted the credit and basked in the glow of favorable public opinion. This status was shortlived and by the early 1960's we were once again headed to a trough of the cycle of public opinion. The roller-coaster ride of public opinion took us to the depths of despair and we have languished there up to the present time.

What happened? The same savior of the medical profession in the 1940's — technology, was also one of the main factors for its loss of public confidence in the 1970's. It was a friend gone astray. While lives were prolonged and new technology appeared every day, it also became painfully obvious that the cost

may be prohibitive. In concert with this was the fact that the thinking of Americans changed between 1945 and 1965. Paul Starr, in the *Social Transformation of American Medicine*, describes this change of thought from one geared toward technology to one concerned primarily with economics and morality. In essence, the thinking of Americans changed while organized medicine continued in the philosophy of the old thinking. This is understandable because emphasis on technology had been present since the mid-1850's. American medicine had declined in prestige during the nineteenth century because we misread the mind of America and clung to the notion that leadership in society would take precedence over scientific principles. Likewise, the medical profession of the 1960's clung to the notion that technology and scientific methods had the superior position in the minds of Americans, not realizing the imperceptible change which had occurred in American society. It was not realized that events had transpired to mold and influence the American mind of the 1960's and 1980's, which would cast a different light on the importance of technology and the medical care of this country.

American medicine had declined in prestige during the nineteenth century because we misread the mind of America and clung to the notion that leadership in society would take precedence over scientific principles.

Retrospectively, the medical profession has largely been saved by external forces throughout its periods of crisis. We have benefitted and profitted from these external forces but the fact remains that often the positive emphasis for reform has not come from within our ranks. Technology and the scientific method are concepts which the whole of culture accepted and approved. However, it was not medicine which was primarily responsible for the technological revolution. It was society as a whole and not until medicine became a part of that movement were we removed from our plight at various times in the history of this country. However, we can no longer expect to be rescued by technology. Therefore, if we cannot expect our traditional ally to bail us out, what are the options?

One option is to let external forces determine the future. There are plenty of those forces ready to do this, including the Congress of the United States, insurance companies, consumer groups and academicians. However, as opposed to before when we have returned from the downside of our cyclic history, we will not be given the credit for this phoenix-like rise from the ashes of despair. Other groups will be given the credit for transforming a seemingly recalcitrant, entrenched profession, archaic in its thinking and concerned only with the financial betterment of its members.

Likewise, the medical profession of the 1960's clung to the notion that technology and scientific methods had the superior position in the minds of Americans, not realizing the imperceptible change which had occurred in American society.

The second option is for bold new initiatives to be proposed by the leaders of medicine. To direct and command these initiatives carries with it an implied understanding that the American mind has replaced technology with emphasis on economics and morality. The new initiatives will have to include ideas and solutions to the care of elderly Americans, addressing not only the medical quality of care, but also how to deal with the spectre of economic ruin from medical catastrophes hanging over the heads of this class of Americans. Also, they will have to address the moral questions of where the available health dollars are to be allotted and in the process will have to answer if it is more ethical and moral for $150,000 to be spent on a heart transplant for an individual or provide maternal care to hundreds of expectant mothers. The profession will have to address the reimbursement of physicians. Is it in the best interest of society for a person to be paid $2000 or more for an hour of work?

Obviously, none of the questions are easy and also just as obvious, some members of the medical profession will be upset that these questions are posed in the first place. Not only must these questions along with hundreds of other questions be asked, but they must also be answered and answered in a way that will balance the expectations of society and the quality of medical care. It is clear to every physician that many of these questions are being asked at the present time and many physicians may feel that medicine is participating in the process. This is true, but medicine has not stepped to the forefront with proposed solutions, which is what is going to be required for medicine to resume a position of credibility. Other elements and institutions are proposing solutions while we discuss and debate it. The emergence of HMOs is an indication that business elements are aware of one of the main trends in American society in the 1970's — fear of financial ruin because of a health problem. HMOs did not emerge because they would provide a quality of medical care superior to the system of care available at that time. No one can argue convincingly that HMOs provide superior care to the traditional practice of medical care available in

this country. What can be argued is that HMOs provide an umbrella against a devastating medical illness which would deplete a person's estate. HMOs hold out the promise of adequate medical care and relief from possible economic ruin. This is an example that the American public has put economics above technology in the sense that pure technology might provide more medical care, but at a price American society is increasingly rebelling against.

In the process of answering these questions, taking the initiative and becoming the leader, it is clear that the medical profession may well alienate some members of its society. There is absolutely no doubt that some physicians' incomes may well be affected and affected adversely in response to many of these questions. However, this is part of the hard decisions that will have to be made by the leaders of medicine. We can no longer afford to sit around and let others make the decisions, but we must step out boldly and propose solutions to the questions that are now being asked by all quarters of society. It is not a question of a few individual physicians, it is a question of the possible survival of an exalted profession that has to be restored to a position of public confidence in this country.

● Dr. Farmer, 405 Downing Street, New Smyrna Beach 32069.

ECHOCARDIOGRAPHY 1986

September 26 - 28, 1986

at

AMI North Ridge General Hospital

Including hands-on sessions and casework on Doppler Principles and recent advancements in Echocardiography and research trends.

Guest Faculty:

Miquel A. Quinones, M.D., Baylor College of Medicine, Houston, Texas

Kent Richards, M.D., University of Texas Health Science Center at San Antonio (Cardiology Division)

Navin C. Nanda, M.D., University of Alabama at Birmingham

Program Directors:

Navin C. Nanda, M.D., F.A.C.C. and Joseph Wanka, M.B., M.A.C.P., F.A.C.P.

This program is partially sponsored by Hewlett Packard and Toshiba. It is being presented by AMI North Ridge General Hospital and The Cardiology Division of the University of Alabama School of Medicine at Birmingham.

Echocardiography 1986 has been approved for 15 Category 1 credits in the Physician's Recognition Award of the AMA and for 15 Prescribed hours by the Academy of Family Physicians.

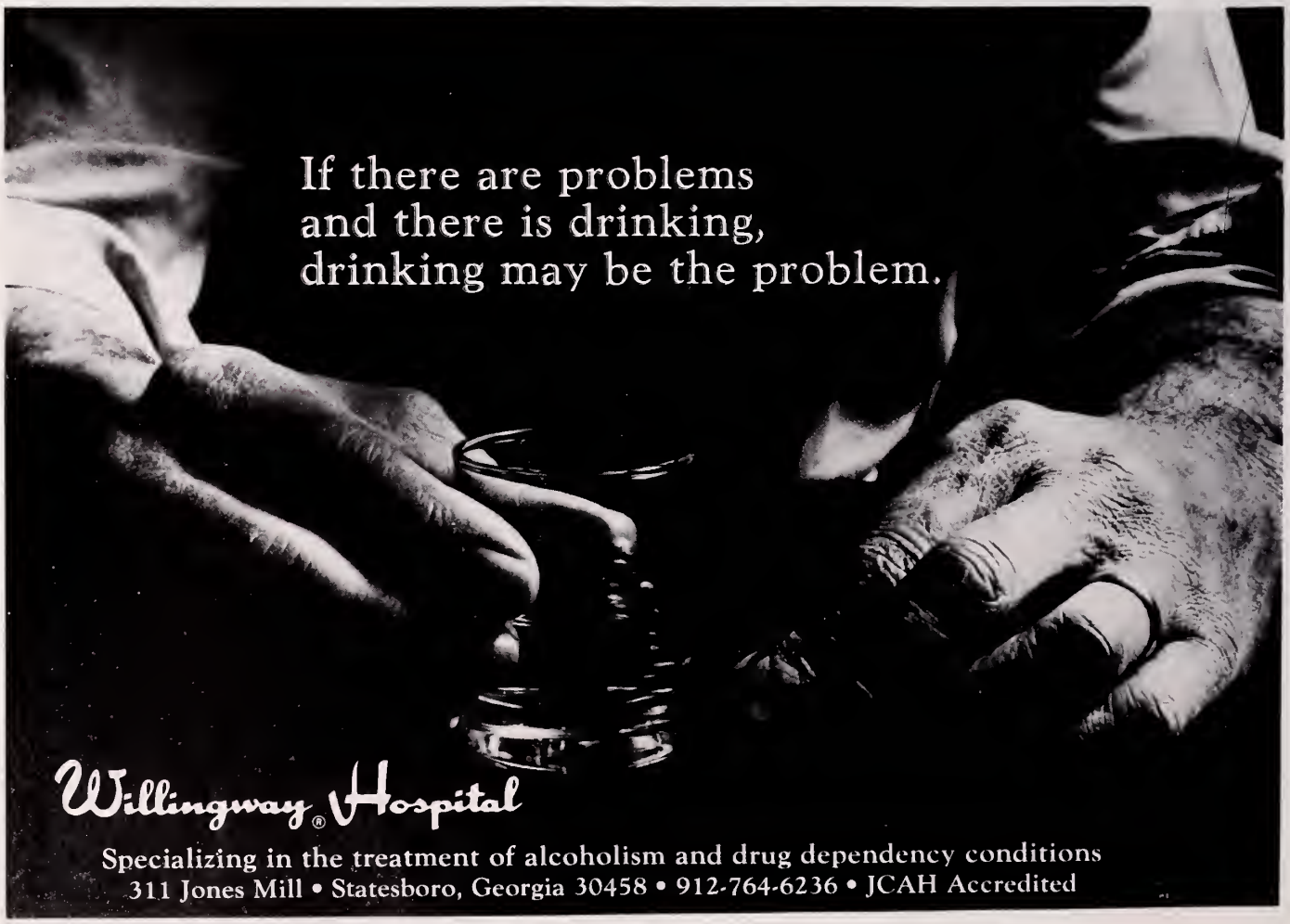
For further information, call: Lee Whiteside-Murphy at 776-6000 or 1-800-523-2561.

Hotel Accommodations:

Embassy Suites: 1-800-EMBASSY. Be sure to indicate that you are part of the North Ridge Hospital Echocardiography symposium.

Dedicated to Excellence in Health Care

5757 North Dixie Highway, Fort Lauderdale, FL 33334 • (305) 776-6000



BUSINESS REPLY MAIL

First Class Permit No. 285 Garden City, NY

Postage Will Be Paid By Addressee

AVIS

Attn: WIZARD NUMBER
P.O. Box 201
Garden City, NY 11530

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

To obtain your special savings, be sure to mention your Avis Worldwide Discount number when making your Avis reservations. And present this card when you pick up your car.

For information or reservations, call Avis toll free:

1-800-331-1212

AVIS

Avis. So easy.SM

For information or reservations, call Avis toll free:

1-800-331-1212

And be sure to mention your
Avis Worldwide Discount number:

AWD #**A/A616900**

Avis Car Groups*



A Subcompact
Chevrolet Chevette
or similar



B Compact
Chevrolet Nova
or similar



C Intermediate
Buick Skylark
or similar



D Full Size, 2-Door
Oldsmobile
Cutlass Supreme
or similar



E Full Size, 4-Door
Buick Century
or similar

*Cars shown and captioned are representative of various makes and models in each car group.

Avis. So easy.℠

Printed in U.S.A. 2-86

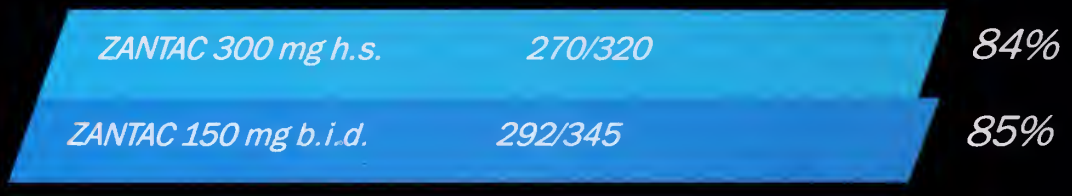
© 1986 Avis Rent A Car System, Inc., Avis*


CONTROL
ACID RAIN
with once-a-night
h.s. therapy for active
duodenal ulcers

Now, one tablet at bedtime

Controls nocturnal acid to relieve pain and heal duodenal ulcers

Heals active duodenal ulcers after 4 weeks in most patients*[1]



In well-controlled, double-blind, multicenter trials, ZANTAC 300 mg h.s. healed active duodenal ulcers in 84% of patients after 4 weeks. After 8 weeks, healing rates may be higher with ZANTAC 150 mg b.i.d. (92%) than with ZANTAC 300 mg h.s. (87%).

Relieves pain and other symptoms as effectively as ZANTAC 150 mg b.i.d.[1]

Zantac® 300

ranitidine HCl/Glaxo 300 mg tablets

Once-daily dosing may enhance compliance in patients for whom dosing convenience is important

Side-effects profile comparable to ZANTAC 150 mg b.i.d.[1-3]

Headache—sometimes severe—has been reported. Rare effects on the CNS, cardiovascular, GI, hepatic, and integumental systems have been observed, as well as rare cases of hypersensitivity reactions. See ADVERSE REACTIONS section of Brief Summary of Product Information before prescribing.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 300 mg h.s. had no significant drug interactions with theophylline or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications which decrease gastric acidity are administered.



*It is not known exactly how much acid inhibition is needed to heal ulcers.

Glaxo / ROCHE

See next page for references and Brief Summary of Product Information.

IN ACTIVE DUODENAL ULCERS

Once-a-night h.s. therapy controls acid rain

Zantac® 300
ranitidine HCl/Glaxo 300 mg tablets

References: 1. Data available on request, Glaxo Inc. **2.** Ireland A, Colin-Jones OG, Gear P, et al: Ranitidine 150 mg twice daily vs 300 mg nightly in treatment of duodenal ulcers. *Lancet* 1984;2:274-275. **3.** Colin-Jones OG, Ireland A, Gear P, et al: Reducing overnight secretion of acid to heal duodenal ulcers. *Am J Med* 1984; 77 (suppl 5B):116-122.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1. Short-term treatment of active duodenal ulcer. Most patients heal within four weeks. Studies available to date have not assessed the safety of ranitidine in uncomplicated duodenal ulcer for periods of more than eight weeks.
2. Maintenance therapy for duodenal ulcer patients at reduced dosage after healing of acute ulcers. No placebo-controlled comparative studies have been carried out for periods of longer than one year.
3. The treatment of pathological hypersecretory conditions (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of active, benign gastric ulcer. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated. Studies available to date have not assessed the safety of ranitidine in uncomplicated, benign gastric ulcer for periods of more than six weeks.
5. Treatment of gastroesophageal reflux disease. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.
2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: There is no experience to date with deliberate overdosage. The usual measures to remove unabsorbed material from the gastrointestinal tract, clinical monitoring, and supportive therapy should be employed.

Studies in dogs receiving doses of ZANTAC® in excess of 225 mg/kg/day have shown muscular tremors, vomiting, and rapid respiration. Single oral doses of 1,000 mg/kg in mice and rats were not lethal. Intravenous LO_{50} values in rat and mouse were 83 and 77 mg/kg, respectively.

DOSAGE AND ADMINISTRATION: Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC®, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NOC 0173-0344-42) and unit dose packs of 100 tablets (NOC 0173-0344-47).

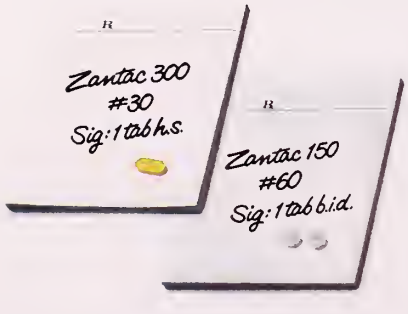
ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NOC 0173-0393-40) and unit dose packs of 100 tablets (NOC 0173-0393-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

© Copyright 1983, Glaxo Inc. All rights reserved. June 1986

Glaxo
Glaxo Inc.
Research Triangle Park, NC 27709

Now...two effective regimens to treat active duodenal ulcers



Physician reimbursement for Medicare beneficiaries (II): implications of regional and national fee schedules

Government representatives and select committees of economists, sociologists, and academicians have been attempting to execute a masterful conjurer's stunt — the development of an equitable payment plan to physicians which will maintain the high quality of care given to Medicare patients while sparing the government budget. The pursuit of this quixotic task has spawned a cloudburst of ideas and policy suggestions as variegated as the daubs of color splashed upon an artist's palette.

Two months ago we briefly glimpsed at capitation — the form of physician reimbursement favored by the Reagan administration. Many problems beset capitation, among them physicians' resistance and the declining interest of most large HMOs and PPOs (whose cooperation will be mandatory to assure the economic viability of a capitated system) to accept the government regulations and risk contracts of capitation schemes.

This month I will examine the feasibility of national or regional fee schedules as a means of reimbursing physicians for Medicare services.

Historically the Medicare reimbursement of physicians has maintained the fee-for-service principle and was patterned after the usual, customary, and reasonable (UCR) charge concept developed by the insurance industry in the 1960's. The "usual" component referred to the servicing physician's common charge as determined by computer screening of his or her fees; "customary" refers to the fee profiles of other physicians providing the same service in the community. The "customary" fee is established at some arbitrary level such as the 75th percentile of all fees charged for that service within the community. "Reasonable" refers to the lower of the "usual" or "customary" fees.

Medicare uses a customary, prevailing, and reasonable (CPR) reimbursement plan. Medicare pays the lowest of (a) the physician's actual charge; (b) the physician's customary charge, or (c) a community-based fee that is as high as 75% of all fees charged for the same service by all physicians in the community.

The inflation of the 1970s and early 1980s caused physician Medicare reimbursement rates to rise commensurate with the national inflation rate. From 1978 to 1983 physician reimbursement expenditures rose almost 14% per year. This rise, which significantly exceeded the inflation rate of other goods and services, has triggered the recent agitation about physicians' fees and has reflexly aroused the search for alternative methods of physician reimbursement. While economists began to stumble through the snowdrifts of this challenge, the government responded by imposing the payment freeze for Medicare reimbursement in October 1984.

Dissatisfaction with Medicare's customary, prevailing, and reasonable reimbursement scheme springs from many reasons. It obviously will not delimit inflation in fees and therefore denies government control of its own expenses. There is a chaotic variation in the amount of reimbursement for a given service. This variation is derived from rural vs. urban practice settings, from differences in the allowances of payment for the services among Medicare carriers across the United States, and from prices charged by individual physicians.

Physician-fee charges for any given service do vary enormously. Cataract extraction fees can vary over 150% from the highest to lowest charge. Charges for chest x-rays vary over 500% . Similar disparities are observed for the charges in all physicians' services. Cost of living differentials account for only a fractional portion of these charge differentials. In some

states, specialists are paid more than nonspecialists, a practice justified by the concept that specialists render more skilled, higher quality service, or a different service. Whether patient outcome is positively affected by a specialist's treatment is difficult to measure, particularly in the office visit setting.

These distortions make it impossible for the government to plan and to analyze its Part B Medicare reimbursement expenses. Patients cannot accurately assess the cost of their medical care since Medicare carriers are so unpredictable in their allowance decisions. Physicians also share in the uncertainty and seldom know at what level a given service will be reimbursed.

The present system is also difficult to administer. Each physician's charges must be recorded and stored and his profile must be updated annually. These charges must then be compared to those of other physicians in every locale in the United States. The administrative difficulties, the lack of control of costs, and the uncertainties attendant with the CPR method of reimbursement have engendered great interest in developing a national fee schedule and relative value scale for physicians' fees.

Relative value scales (RVSs) have been in existence since the 1940s. However, current RVSs are distorted towards high fees to surgical specialists and health care planners would like to adjust them so that the cognitive and procedure-oriented physicians would be more equitably reimbursed. Relative value scales such as that published by the California Medical Association reward surgeons and other procedure-oriented specialists reimbursement fees 5-10 times more per physician — hour input than that rewarded to the general practitioner, family doctor, or internist. Furthermore, inflation and cutbacks in reimbursement to doctors by Medicare have essentially reduced reimbursement to cognitive physician such as FPs and GPs by 1.9% compounded per year between 1973 and 1983 whereas surgeons and anesthesiologists have enjoyed a 2.8% and 4.3% compounded annual gain in their net income as expressed in constant 1973 dollars. Therefore, relative value scales will probably be readjusted. It has been estimated that a "budget-neutral" fee schedule will increase office visit fees to family physicians and general practitioners by 50 and 37%. Surgeon and radiologists will experience fee declines but the actual amount has not been determined. Procedure-oriented internists would probably observe no change in their fees.

Any relative value schedule that is adapted will consider several factors. First is the resource cost for the physician's services. Resource costs include the overhead expenses such as salaries, rents, utilities, supplies, professional liability insurance, and other professional fees in addition to the physician's time input for a given service. The complexity of a particular service or procedure and the opportunity cost of the physician's post-graduate specialty training will also be factored into the relative values.

There are several dangers inherent in such estimates of resource cost. Obviously overhead costs vary significantly from one geographic area to another. None has ever cost-accounted the expenses for performing specific procedures. The American Medical Association and the journal, *Medical Economics*, publish annual reviews of the physician overhead expenses but this review is global, and does not examine individual services, is conducted by questionnaire, and has questionable methodologic problems. Current government literature assumes that overhead cost for physicians average only 40% of gross income. Obviously overhead expenses for some doctors are much greater than those for others. Relatively few physicians enjoy a 40% overhead. More importantly the 40% figure has certainly become obsolete since the imposition of the Medicare freeze and since the reduction in the frequency and duration hospitalization of patients that has occurred over the past three to four years. Since the Medicare freeze was legislated, overhead cost to some physicians has increased 6-10% per year. Physicians formerly accustomed to maintaining a large inpatient hospital census enjoyed a relatively low overhead from such patients. As the amount of inhospital service has declined such physicians and internists have overhead percentages in excess of 60% of gross income. Any fee schedule that is developed by government must accomodate these dramatic changes in physicians' cost. Otherwise, cognitive services to Medicare patients will be found to be too costly for physicians and their quality of care will suffer in the same fashion as that rendered to the indigent and Medicaid patients.

The American Medical Association and the Harvard School of Public Health have been given a grant to develop a new relative value schedule. The Reagan administration opposed the support of this study because it wants to refine and promote its plans for capitation. However, Congress mandated that the HRS secretary develop another relative value scale.

The AMA — Harvard Study is eliminating historical charge data from its consideration. It will focus on the most commonly performed services and procedures and will totally neglect many of the procedures and service items listed in the AMA's Current Procedural Terminology Manual. Relative values will be assigned on resource cost considerations such as time input, complexity of service, requirement for extra office personnel, and other overhead costs. Specific requirements of some specialties will not be addressed. Only family practice, internal medicine, general surgery, ophthalmology, anesthesiology, orthopaedics, obstetrics — gynecology, otolaryngology, pathology, radiology, thoracic surgery, and urology will be treated as separate specialties with identifiably unique skills and considerations. The

study will not be completed until the summer of 1988.

Physician input into relative value schedules may be limited. Some advisors are proposing that the relative value scale be negotiated by a panel of doctors, economists, sociologists, and consumers. Physicians must keep informed about the developments in this area since, once imposed, the RVS will be difficult to alter. Recalibration of the RVS will be conducted periodically but the time frames being considered are long, such as every 24 to 36 months.

Some physicians are reluctant to involve themselves in the discussion of fee schedules because of past Federal Trade Commission suits against several medical associations. But the Federal Trade Commission has modified its consent orders with several medical associations in such a way that a physician group or association is not prohibited from "providing information or views, on its own behalf or on behalf of its members, to third party payers concerning any issue, including reimbursement."[1] Furthermore, antitrust legislation does not apply to fee schedule negotiations between government and medical providers because these laws are effectively repealed for organizations and programs (such as the Health Care Financial Administration and Medicare) established by Congress.

Under a national fee schedule, surgical and most procedural fees will probably be decreased or frozen. Government doctrine holds that an excess of surgery is being performed. The presence of such an alleged excess reflects poorly on the quality of health care to the Medicare population. Health care economists have proposed that reduction of fees paid to procedure-oriented physicians will reduce the performance of many procedures and eliminate the excess. Most physicians will have difficulty comprehending such an Arabesque logic but these kyphotic thought processes are driving the decision-making mechanisms on RVS.

The government advantage to a national RVS is that it would immediately acquire greater control over fees, could impose greater rigidity on the reimbursement system, and could have more flexibility to change any RVS by its own regulatory fiat. Any national RVS would greatly limit the flexibility of physicians in establishing their own fees.

The issue of balance billing is one aspect of a national fee schedule that must be addressed. If the fee schedule does not satisfy the economic needs of physicians, will physicians retain the option of billing the patient for the amount of fee that is disallowed by a new fee schedule? Government obviously wants to prohibit balance billing but it also recognizes that Medicare must assure quality of and access to care. Government favors greater physician participation in the Medicare program since this is administratively simpler and politically expedient. However, the majority of physicians will not accept assignment because of the inequalities in the fees, the inability to accurately predict reimbursement amounts, and the great delays in payment. Most physicians who now accept assignment are procedure-oriented and receive relatively high reimbursements in comparison to office-based physicians.

The attitude of government planners is that a national fee schedule must establish reimbursement at levels so that 50% or more physicians will participate in the Medicare program. This must be accomplished in a "budget-neutral" manner, i.e., one that does not immediately increase Part B Medicare costs. Obviously this will be difficult.

Another issue that requires confrontation is the establishment of conversion factors of the RVS into actual allowed reimbursement. Most likely conversion factors will differ geographically over the nation. No one has addressed the issue of frequency of updating or readjustment of conversion factors as economic changes occur within different regions of the country.

One AMA economist estimates that a national RVS has a fifty percent probability of being adopted. Neither a new RVS nor capitation is a delectable choice for physicians. My prediction is that capitation will prove too risky for quality HMOs or PPOs to undertake and capitation will not be salable to them. Failure of participation of quality HMOs and PPOs in the Medicare system will forfeit the Medicare patient care to HMOs of dubious credibility — such as International Medical Centers of Miami. Fortunately the national ruckus inspired by the activities of International Medical Centers makes this politically unjustifiable for the administration. This leaves a national fee — RVS combination as the most likely compromise vehicle for eliminating much of the administrative confusion contained in the present fee system.

References

1. U.S. Federal Trade Commission, letter to Mr. Rickard F. Pfizenmayer, Esq., April 19, 1985.
2. Payment for Physicians Services Strategies for Medicare Office of Technology Assessment, Washington, D.C. 20510, February 1986.

Jacques R. Caldwell, M.D.
Daytona Beach

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

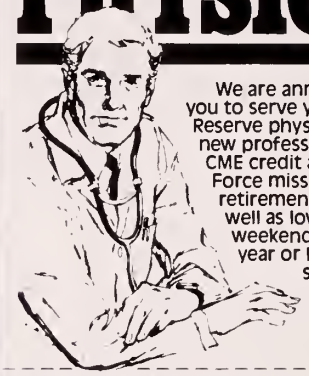
Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

PHYSICIANS

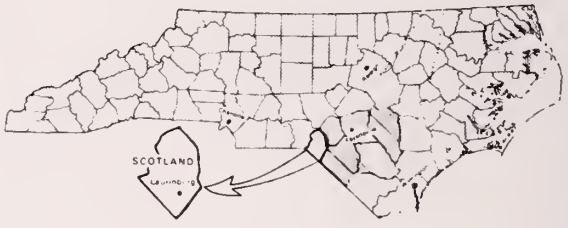


We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HQ 10 AF/RSH
Bergstrom AFB, TX 78743-6002
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Prior Service? Yes ___ No ___
Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE



North Carolina

A strong medical community is seeking American Board Certified physicians to practice in a new 125-bed (all private rooms) not-for-profit hospital, state of the art equipped, located in a college community with over 25 major industries.

SPECIALTIES

Orthopaedics	Internal Medicine
Ophthalmology	(Gastroenterology)
Otolaryngology	(Pulmonology)
Obstetrics/Gynecology	Urology

Family Medicine

Please send CV in confidence to:
Physician Recruitment Committee
Scotland Memorial Hospital
500 Lauchwood Drive
Laurinburg, N.C. 28352
Attn: W.H. Davidson, M.D.

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 631
- ☐ 112th ANNUAL MEETING, 632
- ☐ DEAN'S MESSAGE, 636
- ☐ ENCORES!, 637

NOTES & NEWS

IAG accepting entries for Sandoz Gerontology Prize

Calling gerontology research a priority for scientists in the coming decades, Craig D. Burrell, M.D., Vice President, Sandoz Corporation, today announced that applications for the third Sandoz Prize for Gerontological Research will be accepted through October 31, 1986.

The prize — 20,000 Swiss francs, or approximately $11,000 U.S. — will be awarded by Sandoz, Ltd., Basle, Switzerland, at the first European Congress of the International Association of Gerontology (IAG), Brighton, U.K., in September, 1987.

"The challenge for scientists is to improve the quality of life in later years," Dr. Burrell said. "This prize is meant to foster research to help achieve this goal."

The Sandoz Prize for Gerontological Research is awarded for major contributions to the establishment and development of a field of research in gerontology rather than for a specific paper, Dr. Burrell explained.

Entries are accepted from individuals, groups and institutions directly engaged in research in some area of gerontology or geriatrics, and may take the form of published or unpublished work, documented as normally required for scientific publications. Entries may be written in any language but must have a detailed English summary of approximately three to five pages describing the field covered. Up to three major papers may be submitted.

In addition to the entry, a curriculum vitae and a list of published works for each member of the group should be included. Only research that has already been carried out will be considered. The Sandoz Prize, Dr. Burrell explained, should not be seen as a means of financing new projects or as a research grant.

Entries should be addressed to Manfred Bergener, M.D., Coordinator IAG, Rheinische Landesklinik, Wilhelm-Greisinger-Strasse 23, D-5000 Koln 91, Federal Republic of Germany.

The jury is composed of the Executive Committee of the IAG, its official Sandoz coordinator and one representative of Sandoz Ltd. In judging the entries, particular importance is attached to interdisciplinary research efforts, including such diverse fields as genetics and dementia.

Previous winners of the Sandoz Prize were Professor C.F. Hollander of the Netherlands and Professors E.W. Busse and G.L. Maddon of Duke University in North Carolina (1983); Dr. Karl Esser of West Germany and Professor Sir Martin Roth, head of the Department of Psychiatry, Cambridge University, U.K. (1985).

Chernobyl bone marrow transplant expert to brief U.S. physicians via video

Four months ago most people had never heard of the city. Today, the world views it through a microscope. Could Chernobyl happen to us? Are we prepared? Robert P. Gale, M.D., the American bone marrow transplant specialist who went to the nuclear accident site shares his experiences which may help provide answers to some of the many questions being raised.

A physician-to-physician interview with Dr. Gale is featured in a new videotape program produced by the Network for Continuing Medical Education. "Chernobyl: Robert P. Gale Reports" will be available at 700 hospitals and medical schools throughout the nation in September, 1986.

Robert P. Gale, M.D., Ph.D., is Associate Professor of Medicine at the UCLA School of Medicine, and Chairman of the International Bone Marrow Transplant Registry. He has made two subsequent trips to Moscow to perform bone marrow transplants on some of the 300 more seriously affected victims flown in from the Kiev area. Twenty-six deaths have now been reported as a result of the accident, and Dr. Gale and his team, along with the Soviet scientists, will continue to study the long-term effects on the health of the 100,000 people who lived near the accident site.

The interview is conducted by bone marrow transplantation expert Frederick R. Appelbaum, M.D., Associate Professor of Medicine, University of Washington School of Medicine, and Associate Member of the Fred Hutchinson Cancer Research Center in Seattle. The program, divided into four segments, opens with a discussion of what Dr. Gale found upon arriving in the Soviet Union — symptoms of those affected, how the team determined who

should receive transplants, how donors were located, and what the local medical facilities provided for the victims.

This is followed by Dr. Gale's report on his initial course of action, including how he estimated amounts of radiation exposure, and his evaluation regarding the outcome of the plan of action. The interview concludes with Dr. Gale's personal views on how physicians can better prepare themselves should a similar accident happen here.

Established in 1965 with the support of Roche Laboratories, Division of Hoffmann-La Roche, Inc., NCME releases a one-hour videotape every two weeks throughout the year. Since its founding 21 years ago, more than 1,200 continuing education programs for the medical profession have been produced and distributed to hospitals and medical schools throughout the U.S. and Canada.

National philanthropy recognizes eye care helpline for elderly

The National Eye Care Project, a program offering medical eye care and information to older Americans who cannot afford it, has received a $49,575 grant from the Robert Wood Johnson Foundation.

The Foundation, a national philanthropy based in Princeton, N.J., has made grants in excess of $650 million to improve health care in the U.S. since 1972.

The $49,575 grant will be used to support the toll-free Eye Care Helpline — 1-800-222-EYES — for U.S. citizens and legal residents age 65 or over who do not have an eye physician, or have not seen one in three years or more.

"This recognition is heartening because of the Foundation's emphasis on projects to improve access to personal health care for underserved population groups, " said Bruce E. Spivey, M.D., Executive Vice President of the American Academy of Ophthalmology.

"This is exactly what we are trying to do for older Americans who have medical eye problems, but who do not have an eye physician," Spivey said. "They are often the hardest to reach, even though they need medical eye care the most."

Through the program, ophthalmologists have examined more than 40,000 older Americans, and treated nearly 30,000 for cataracts, macular degeneration, glaucoma and other eye diseases. Nearly 32 percent had never had an eye exam until they called the Helpline and were referred to one of the program's 7,000 volunteer eye physicians.

Helpline patients who are not covered by Medicare or other medical insurance will be cared for at no out-of-pocket expense. For those who are covered, insurance payments will cover the cost of the ophthalmologist's services.

Older individuals are particularly vulnerable to debilitating eye diseases such as cataracts, glaucoma, macular degeneration and diabetic retinopathy, which can often be corrected or cured before they cause blindness, Dr. Spivey said.

The National Eye Care Project toll-free Helpline has been opening region by region since Jan. 6, 1986, and will be operating nationwide by July 22, weekdays 8:00 am to 5:00 pm in every time zone. The project is co-sponsored by the Foundation of the American Academy of Ophthalmology and ophthalmology societies in all 50 states.

Hospital association offers free hurricane preparedness brochure

June through November is hurricane season in South Florida. The South Florida Hospital Association is offering a free brochure, *Hurricane Preparedness*, that explains what you can do to protect yourself and property in the event of a hurricane.

Hurricanes have the power to slam into Florida's shoreline with 200 mile-per-hour winds and tides that can surge up to 18 feet or more above mean sea level. "The South Florida area has been extremely lucky in recent years," says George Berch, president of the Association. "Many people, new residents as well as long-time ones, do not take the dangers of a hurricane seriously. They do not realize the destruction and loss of life that can occur if proper safety measures are not taken."

To assist residents in preparing for the hurricane season, the SFHA, in cooperation with the Dade County Chapter of the American Red Cross and Florida Power and Light Company, has published *Hurricane Preparedness*. For a free copy, in English or Spanish, contact the South Florida Hospital Association, 8245 N.W. 53rd Street, Suite 200, Miami 33166-4609, or call in Dade County (305) 591-8020 and in Broward County (305) 522-3433.

112th ANNUAL MEETING

Scientific program complete

The 112th Annual Meeting scientific program has been completed under the leadership of Pierre J. Bouis Jr., M.D., Chairman of the Council on Scientific Activities and Committee on Medical Education Chairman, Orris O. Rollie, M.D. Program highlights are listed below and as in the past, up to 15 hours of AMA Category I credit will be available to program registrants.

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy and Immunology Society)
Saturday, September 20, 1986 — 8:00 a.m. to 12:00 noon
Michael A. Diamond, M.D., Daytona Beach
Program Chairman

Welcome — Roger W. Fox, M.D., President, Florida Allergy and Immunology Society, Tampa

"The Use of Inhaled Bronchodilators in Bronchial Asthma — How Much is Too Much?" — John Stablein, M.D., Assistant Professor of Medicine, Division of Allergy, University of South Florida College of Medicine, Tampa

"Aspirin Sensitivity in Bronchial Asthma" — Guy Settipane, M.D., Associate Clinical Professor, Department of Medicine, Brown University; Co-Director, Allergy Division, Rhode Island Hospital, Providence, Rhode Island

"Nasal Polyps" — Guy Settipane, M.D.

Break

"Pathologic Findings and Clinical Correlations with Drug Use in the Heart and Lungs of Patients Who Die of Bronchial Asthma" — Philip Korenblat, M.D., Associate Professor of Medicine (Clinical), Washington University School of Medicine, St. Louis, Missouri

Discussion

Luncheon and Business Meeting

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians and Florida Thoracic Society)
Thursday, September 18 — 1:30 p.m. to 4:30 p.m.
Mark Snider, M.D., Miami
David Solomon, M.D., Tampa
Program Chairmen

"Chest Trauma" — Richard Thurer, M.D., Associate Professor of Surgery, Division of Thoracic and Cardiovascular Surgery, University of Miami School of Medicine

"Mixed Venous Oxygen Saturation" — Allan Feingold, M.D., Assistant Director of the Department of Pulmonary and Hyperbaric Medicine, South Miami Hospital; Associate Clinical Professor of Medicine, University of Miami School of Medicine

"Respiratory and Intensive Care Monitoring" — Bruce Krieger, M.D, Co-Director, Intensive Care Unit, Mount Sinai Medical Center; Associate of the Division of Pulmonary Medicine, Mount Sinai Medical Center; Assistant Professor of Medicine, University of Miami School of Medicine

Questions and Answers

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)
Friday, September 19 — 2:00 p.m. to 5:00 p.m.
Kimber A. Ward, M.D., Clearwater
Program Chairman

"Abdominal-Perineal Resection — The Bottom End" - W. Patrick Mazier, M.D., Ferguson Clinic, Grand Rapids, Michigan

"Infrared Photocoagulation in Treatment of Hemorrhoids" — Carlos Alvarez, M.D., Miami

"Alternative Treatment of Hemorrhoids" — Emmet F. Ferguson, M.D., Jacksonville

"Transrectal Excision of Rectal Cancer" — Frederick N. Herman, M.D., Plantation

"Laser Therapy for Rectal Cancer" — Harvey Shub, M.D., Orlando

"The Surgical Treatment of Anal Fistulas in Crohn's Disease" — W. Patrick Mazier, M.D.

"Colonoscopic Excision of Large Sessile Polyps" — John Christie, M.D., South Miami

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)
Thursday, September 18 — 3:00 p.m. to 5:00 p.m.
Saturday, September 20 — 8:30 a.m. to 12:00 noon
David Arrowsmith, M.D., Ft. Walton Beach
Program Chairman

SECTION ON PREVENTION

(Co-sponsored by the Florida Chapter, American College of Emergency Physicians, Florida Society for Preventive Medicine and Florida Occupational Medical Association)
Thursday, September 18 — 1:00 p.m. to 5:00 p.m.
Brian J. Ellis, M.D., Orlando
Donald S. Kwalick, M.D., Tampa
James Byrne, M.D., Miami
Program Chairmen

Welcome

"AIDS Update" — John Witte, M.D., Medical Administrator, Department of Health and Rehabilitative Services, and Michael Wilder, M.D., Epidemiologist, Department of Health and Rehabilitative Services

"Drug Abuse in Industry" — Stephen Kahn, M.D., Highland Park Hospital

"Emergency Treatment of Poisoning" — TBA

"Occupational Health in the Wood Pulp and Paper Industry" — Mr. Michael Dietch, Winner of Joseph E. Baird FOMA Award for 1986.

SECTION ON ENDOCRINOLOGY

(Co-sponsored by Florida Endocrine Society)
Friday, September 19 — 2:00 p.m. to 5:00 p.m.
Amid Habib, M.D., Altamonte Springs
Program Chairman

"Fine Needle Biopsy of the Thyroid Gland" — H. Jack Baskin, M.D., Florida Thyroid and Endocrine Clinic, Orlando

"Thyroid Nodules" — Nelson Watts, M.D., Associate Professor of Medicine, Emory University, Atlanta, Georgia

"Lipid Disorders — 1986" — Ronald Goldberg, M.D., Associate Professor of Medicine, University of Miami

SECTION ON DIABETES

(Co-sponsored by Florida Affiliate of the American Diabetes Association)
Saturday, September 20 — 8:00 a.m. to 12:00 noon
Arlan L. Rosenblum, M.D., Gainesville
Program Chairman

"New Developments in Type I Diabetes — Including Immunosuppression, Transplantation, and Intensified Insulin Treatment" — John I. Malone, M.D., Professor of Pediatrics and Co-Director of the Diabetes Center, University of South Florida, Tampa

"New Developments in Type II Diabetes" — Ronald Goldberg, M.D., Associate Professor of Medicine, University of Miami School of Medicine

"Florida's Diabetes Centers Program" — Arlan L. Rosenbloom, M.D., Professor of Pediatrics and Program Director of the University of Florida Diabetes Research, Education and Treatment Center, Gainesville

"Exercises in the Problem of Compliance" — Suzanne Johnson, Ph.D., Associate Professor of Psychology, Pediatrics, and Psychiatry, University of Florida; Wendy Satin, M.S.W., University of Miami School of Medicine

SECTION ON FAMILY MEDICINE

(Co-sponsored by Florida Academy of Family Physicians and Pfizer Pharmaceuticals)
Friday, September 19 — 2:00 p.m. to 5:30 p.m.
Lee A. Fischer, M.D., West Palm Beach
Program Chairman

Welcome

"Hypertension and CHD Risk Factors" — Norman M. Kaplan, M.D., Director, Hypertensive Unit, University of Texas Science Center, Dallas, Texas

"Infections in the Immunosuppressed Patient" — John S. MacDonald, M.D., Department of Internal Medicine, University of Kentucky Medical Center, Lexington, Kentucky

"Cardiovascular Emergencies" — Alan B. Miller, M.D., Chairman, Department of Cardiology, University Hospital of Jacksonville

"Cost Effective Practice/Medical Office Management" — Jack R. Gregg, Ph.D., Director, Health Services, Management Program, Graduate School of Management, Dallas, Texas

SECTION ON INTERNAL MEDICINE

(Co-sponsored by Florida Society of Internal Medicine and American College of Physicians)
Thursday, September 18 — 1:00 p.m. to 3:00 p.m.
Wilbert L. Dawkins Sr., M.D., Jacksonville
Panagiota Caralis, M.D., Miami
Program Chairmen

"Lymphoma — 1986" — Jack D. Temple, M.D., Assistant Professor of Medicine, Division of Hematology, University of Miami School of Medicine

"Renal Transplantation" — David Roth, M.D., Assistant Professor of Medicine, Division of Nephrology, University of Miami School of Medicine

"Cardiac Disease in the Elderly" — Panagiota Caralis, M.D., FACP, Associate Professor of Medicine, University of Miami School of Medicine

"Percutaneous Transluminal Coronary Angioplasty" — Andres R. Palomo, M.D., Assistant Professor of Medicine, Division of Cardiology, University of Miami School of Medicine

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)
Saturday, September 20 — 7:30 a.m. to 12:00 noon
Jack Fealy, M.D., West Palm Beach
Program Chairman

"Seasonal Variations in the Diagnosis of Uterine, Ovarian and Cervical Malignancies" — Carole Neuman, M.D., Jacksonville

"Primary Squamous Cell Carcinoma of the Uterus" — A. Abu-Hamad, M.D., Gainesville

"Treatment of Pelvic Endometriosis with the CO2 Laser" — John Van Wert, M.D., Gainesville

"Estimation of Fetal Weight in Pre-Term Pregnancies With and Without Ruptured Membranes" — Stewart Newman, M.D., Jacksonville

"Treatment of Recurrent and Metastic Cervical Cancer with Cisplatin, Doxorubicin and Cyclophosphamide" — Mitchell Hoffman, M.D., Tampa

"Post-Partum Endometritis after Vaginal Delivery" — Jeff Heitmann, M.D., Ponte Vedra

Break

"Incidental Appendectomy in OB-GYN Surgery" — Marc Schlosser, M.D., Boca Raton

"A Prospective Randomized Double Blind Study of the Use of Prostaglandins for Cervical Dilatation in Non-Pregnant Women" — Cynthia Flanders, M.D., Jacksonville

"Vulvar Intraepithelial Neoplasia and Smoking" — Jean Cook, M.D., Gainesville

"Maternal Serum Alpha Fetal Protein" — R. Muawwad, M.D., Miami

"An Evaluation of the Clinical Staging of Endometrial Cancer" — Kevin Campbell, M.D., Ft. Myers

SECTION ON CLINICAL ONCOLOGY

(Co-sponsored by Florida Society of Clinical Oncology and Florida Radiological Society)
Friday, September 19 — 2:00 p.m. to 5:00 p.m.
Everett Shocket, M.D., Miami
Program Chairman

"Surgical Approach to Care of Prostate and Bladder Cancer" — Zev Wajsman, M.D., Director, Urologic Oncology, Professor of Surgery, University of Florida College of Medicine, Gainesville

"Medical Oncologic Treatment of Prostate and Bladder Cancer" — Marc B. Garnick, M.D., Staff Oncologist, Dana-Farber Cancer Institute, Associate Professor of Medicine, Harvard Medical College, Boston, Massachusetts

Break

"Full-Dose Irradiation in the Treatment of Patients with Invasive Bladder Carcinoma — Alone or in Concert with Chemotherapy" — William U. Shipley, M.D., Associate Professor of Radiation Therapy, Associate Director, MGH Cancer Center, Boston, Massachusetts

Questions and Answers

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology and Florida Society of Otolaryngology)
Saturday, September 20 — 9:00 a.m. to 12:00 noon
Harry W. Flynn, M.D., Miami
Program Chairman

SECTION ON ORTHOPEDICS

(Co-sponsored by Florida Orthopedic Society)
Saturday, September 20 — 8:00 a.m. to 12:00 noon
Russell C. Sklenicka, M.D., Lakeland
Program Chairman

"Economic and Legal Influences on the Practice of Orthopaedics in the State of Florida — 1986-1987" — Presentation made by Richard Hodes, M.D., Tampa, and members of the Florida Orthopedic Society

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists, Florida Pediatric Society and Florida Medical Examiners Commission)
Saturday, September 20 — 8:25 a.m. to 12:00 noon
Wallace M. Graves, M.D., Ft. Myers
Louis B. St.Petery Jr., M.D., Tallahassee
Program Chairmen

"Child Abuse Panel" — David Smith, Ph.D., Chief, Division of Medicine and Human Values, University of South Florida College of Medicine, Tampa; Ronald Reeves, M.D., Associate Medical Examiner, District 18, Melbourne; Isaac B. Koran, J.D., Assistant Public Defender, First Judicial Circuit, Pensacola; Michael Cupoli, M.D., Associate Professor of Pediatrics and Maternal/Child Health, University of South Florida College of Medicine, Tampa; Ronald K. Wright, M.D., District Medical Examiner, District 17, Ft. Lauderdale

SECTION ON PEDIATRIC CARDIOLOGY

(Co-sponsored by Florida Association of Pediatric Cardiologists)
Friday, September 19 — 2:00 p.m. to 5:00 p.m.
Jorge Giroud, M.D., St. Petersburg
Program Chairman

"Coronary Artery Abnormalities in Children" — Group Discussion with six case presentations

SECTION ON PEDIATRIC SURGERY

(Co-sponsored by Florida Association of Pediatric Surgeons)
Saturday, September 20 — 7:30 a.m. to 11:30 a.m.
James A. Borger, M.D., St. Petersburg
Program Chairman

"Latest Advances in Extracorporeal Membrane Oxygenation" — Robert Arensman, M.D., Pediatric Surgeon, New Orleans, Louisiana
Case Presentations

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)
Saturday, September 20 — 7:30 a.m. to 12:00 noon
Edwin M. Villalobos, M.D., Orlando
Program Chairman

Welcome
"Head Injury: Acute Care Diagnosis and Prognosis" — Barth Green, M.D., Professor of Neurosurgery, Orthopedics and Rehabilitation, University of Miami School of Medicine
"Neuropsychology in Head Injuries" — Henry Van Twyver, Ph.D., Casa Colina, Orlando
Theoretical and Treatment Considerations Specific to Cognitive Rehabilitation" — Gail Lingor, M.S., CCC-SP Associate Evaluator, New Medico Head Injury Foundation, Jacksonville

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgeons)
Saturday, September 20 — 9:00 a.m. to 11:00 a.m.
Calvin R. Peters, M.D., Orlando
Program Chairman

Panel Discussion — Calvin R. Peters, M.D., Moderator
Panel — Paul Schnur, M.D., Chairman, Socioeconomic Committee, American Society of Plastic and Reconstructive Surgeons; Mr. Robert Johnson, Insurance Consultant, American Society of Plastic and Reconstructive Surgeons; Gerald Cousins, M.D., Medical Director, Blue Cross/Blue Shield of Florida; Luis M. Perez, M.D., President, Florida Medical Association, Inc.

SECTION ON PSYCHIATRY

(Co-sponsored by Council on Florida District Branches of the American Psychiatric Association)
Friday, September 19 — 2:00 p.m. to 5:00 p.m.
Saturday, September 20 — 9:00 a.m. to 12:00 noon
John E. Adams, M.D., Gainesville
Program Chairman

SECTION ON RADIOLOGY

(Co-sponsored by Florida Radiological Society, Inc.)
Friday, September 19 — 2:00 p.m. to 5:00 p.m.
Saturday, September 20 — 9:00 a.m. to 11:45 a.m.
Stephen Schoenbaum, M.D., Hollywood
Program Chairman

Friday, September 19
"Computerized Tomography of the Orbit" — Robert Shapiro, M.D., Professor of Radiology, University of Miami School of Medicine, Jackson Memorial Hospital
"Interventional Cardiovascular Radiologic Techniques" — Stephen Schoenbaum, M.D., Clinical Associate Professor of Radiology, University of Miami School of Medicine, Hollywood Memorial Hospital
"Sialography" — Joel Schneider, M.D., Clinical Associate Professor of Radiology, University of Miami School of Medicine, Hollywood Memorial Hospital

Saturday, September 20
"Magnetic Resonance Imaging of the Spine" — Jeffrey Tobias, M.D., Assistant Professor, University of Miami School of Medicine, Mount Sinai Medical Center
"Magnetic Resonance Imaging of Vascular Disorders of the Brain and Spinal Cord" — Jeffrey Tobias, M.D.
"Diagnostic Breast Imaging" — Raul Matallana, M.D., Professor of Radiology, University of Miami School of Medicine, Mount Sinai Hospital

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Rheumatology)
Saturday, September 20 — 9:00 a.m. to 12:00 noon
M.F. Mass, M.D., Jacksonville
Program Chairman

"Current Techniques in Joint Replacement" — William Thomas, M.D., Brigham and Women's Hospital

SECTION ON SURGERY

(Co-sponsored by Florida Association of General Surgeons, Florida Chapter, American College of Surgeons, and Florida Society of Thoracic and Cardiovascular Surgeons)

SECTION ON CHEMICAL DEPENDENCY

(Co-sponsored by the Florida Medical Foundation Committee on Impaired Physicians and the Florida Chapter, American Medical Society on Alcoholism)

Wednesday, September 17 — 1:30 p.m. to 4:30 p.m.

Arvey I. Rogers, M.D., Miami

E. Joan Barice, M.D., Singer Island

Program Chairpersons

"Substance Abuse: A View from the Top" — Donald I. Macdonald, M.D., Administrator, Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), Washington, D.C.

Discussion and Questions and Answers — Moderators: Guy T. Selander, M.D., Chairman, FMF Committee on Impaired Physicians, Jacksonville; Roger A. Goetz, M.D., Medical Director, FMA/FMF Impaired Physicians Program, Jacksonville

Break

"Cocaine, Alcohol and other Chemical Dependencies: Early Detection and a Look Inside the Family"

Introduction — John C. Eustace, M.D., Addiction Treatment Unit, Mount Sinai Medical Center, Miami Beach

"The Family Illness: Terminology, Dynamics, Concepts of Recognition and Treatment" — Ronald J. Catanzaro, M.D., Medical Director, The Palm Beach Institute, West Palm Beach

Break

Sharing by Individual Recovering Family Members

Panel of Recovering Family Members: Questions and Answers — Dr. Catanzaro, Moderator

DEAN'S MESSAGE

A case for example

Imitation may indeed be the most sincere flattery, but those who are imitated, beware! It is also the means by which doctors in training complement all of the book-hours of formal medical education.

At this point, there should be no mistake. This writing is neither a condemnation of imitation nor a critique of medical education. Rather, it is an observation of a student meant to be shared with physicians and physicians-to-be at any level of experience: for those physicians who stand as examples for others, there can be no greater disappointment than to discover that the most sincere imitation is not flattering.

At the outset, it should be obvious that doctors who are not clinical professors are not immune from observation. After all, people who become doctors are first the patients, and perhaps the children of doctors. They are, in many cases, the relatives of men and women who have been under a physician's care for serious illness. The watchful child may decide that he would like to grow up to be just like the doctor he has known, but it is possible that he is motivated instead by a desire to grow up to be a better doctor than the one he has known. From a person's earliest years, then, a doctor's example may be the thesis or the antithesis of what an individual wants to become.

Thus the medical student approaches his task with preconceived notions concerning the behavior of physicians. Subsequent experience with the individuals who train him in medicine will determine to a significant extent how his ideals and standards change. The higher the standards of professionalism of the physicians and residents and older medical students he meets, then the harder their conduct will be to imitate. Medical students need the challenge of emulating truly professional behavior. It is far too easy to fall in step with what others, whether peers or teachers, are doing than to adhere to a finer code, especially without the support of peers and the insistence of teachers.

We continue now to consideration of what medical students and their teachers can do to maximize the benefits of the informal medical lessons learned through observation. Three "classrooms" of such learning will be addressed. The first classroom is the examining room, the second is the lecture hall, and the third is any setting in which doctors come together for recreation and relaxation.

Discussion of the examining room is an appropriate beginning. It is a very special place in which privileged lay persons turn into medical professionals by virtue of a patient's consent. Persons who agree to accept care in part from student doctors and residents, no matter what the reason, give of themselves in a manner which is especially generous in light of the burden of illness. The uniqueness of such a person has been sometimes forgotten when two or more health care providers gather in the examining room. Medical students and residents awaiting an overdue attending physician may fill the time and the patients' waiting room with clamorous discussions about their vacation plans, their personal lives, or their latest investments. While these topics of discourse are disagreeable to practically no one, they serve the unfortunate function of fueling patient alienation from, and perhaps distrust of, the medical profession as a whole. Students' and doctors' conversations about either the deficits or the prosperity of their lives provide too marked a contrast to the concerns of those seeking an advocate for their health. Few are forthright enough to squelch the chatter of colleagues or students. More of us should consider doing so.

When two or more training doctors are seeing patients along with either a physician in private practice or a clinical professor, the experience is often very enriching for both pupils and teachers. A certain case may be so engrossing that the patient is unconsciously excluded from the exchange, even when value judgements are involved. We can imagine, for example, a woman who keeps routine appointments at a well known clinic for the monitoring of an advanced visceral cancer. On one of the days that she visits the clinic, she is in obvious distress because of a complication of the neoplasm's extension, but she is not com-

plaining. The lady declined surgery a few months earlier out of a desire to retain certain functions, but by now the tumor has destroyed these cherished functions. She is sharply reminded of her choice and of its consequences during her case presentation before an audience of ten. The resident adds that none of this would have happened had she been smarter, that is, receptive to doctor's advice. What may appeal to the inexperienced who seek a successful style is the authoritative tone of such commentary, but surely, this information could be conveyed with more gentility in the presence, and for that matter, in the absence, of the distressed woman.

We can also imagine a man in an adjacent treatment room. He is prepared to undergo a topical procedure that is performed relatively infrequently. The novelty of the treatment attracts many observers. The door is left wide open, and curious medical personnel crowd in to see what is going on. The patient, who looks away and keeps silent, has become a secondary prop in the arena of medical education. The doctors carrying out the procedure talk busily and cheerily, but not about the task at hand, and not at all with the patient, who is so engaged for the better part of an hour. The individual in charge can maximize the educative potential and minimize the patient's distress by choosing only a handful of persons to assist in and to watch the teaching procedure.

The next setting in which imitative learning may occur is the lecture hall. As the abode of first and second year medical students, it is the stage for introductions to normalcy and disease. The men and women who present class material lay the groundwork for students' understanding of disease processes in the clinical years. Lecturers may also be aware that there is a loose correlation between the flamboyance of the delivery and the attention of the audience. As a result, there is a temptation to discuss the juiciest, most unusual cases to impress the listeners. Nevertheless, patients' stories warrant discretion, too. It is not the unusual cases themselves, but the value judgements often tacked on to them, that are objectionable. Influential speakers are apt to pass on their biases to receptive listeners. While most do not reveal their true opinions to patients, some will relate their judgements to colleagues and groups of medical students within lecture halls. Speakers are therefore asked to cite remarkable cases with care and to discourage sensationalism in the medical classroom.

We turn at least to the informal setting — the party or chance meeting — that brings medical professionals together. It is a realm of consults and vocational exchange, a vital network of information. New doctors and students study successful behavior in others both on and off duty, however. Staying in role all the time is as impractical as it is impossible, yet in dealings with associates, gross incongruities are disconcerting. For example, one cannot help but wonder why a respected specialist amuses others with poignant jokes about the kinds of people who seek his care. Hopefully, such individuals are few, but any person who conducts himself carelessly can impress the newest entrants into the profession with inappropriate attitudes and values. Consistency is probably a better policy than permissiveness for people who are likely to be copied.

Coming to the conclusions of this writing, it may seem that the training doctor fits a description that William Wordsworth penned long ago: "As if his whole vocation were endless imitation!" Medicine is not, of course, as basic as copying what others do, but the predecessors of the incoming physicians have a great impact on the shape that the new physician assumes. People who interact with developing doctors can complement the rigor of modern training in an invaluable way by providing examples of solid professional standards. As students model their actions after the conscientious physicians they observe, we will find that the good imitations are recognized because they reflect the qualities of the valued originals. The poor imitations must be either weak suggestions of what they wanted to be, or true images of imperfect prototypes.

Loretta J. Register, MS III
University of South Florida
College of Medicine
Tampa

Reprinted with permission from *The Bulletin of the Hillsborough County Medical Association*, May 1986.

ENCORES!

Is it time to raise the rates?

Physicians have always been paid more for performing technical procedures than they have for "cognitive" servces, that is, for spending time thinking about and caring for patients. Indeed, no one can dispute that the more a physician does to a patient, the more he or she gets paid. This irrational payment system has been aggravated over the years by government and private health-insurance payment schemes that reinforce disincentives for cognitive services. In fact, according to a 1979 study for the Health Care Financing Administration, we have reached a point where office visits are undervalued by a factor of between two and three to one when compared with surgical procedures.

Should cognitive skills, which require perhaps the highest levels of intellect, rate the lowest levels of compensation? Certainly not. The imbalance creates

a potentially perverse financial incentive that negatively influences the care Americans receive and likely contributes to the public perception that medical care is too costly, inefficient, and impersonal. Moreover, unless the situation is resolved, this historical inequity and its side effects may continue to increase, especially now that public and private payors, in their efforts to combat rising health-care costs, are calling for reform in the fees for physician services.

In this debate, the American Society of Internal Medicine (ASIM) has introduced the concept of seeking more equitable payment for cognitive services. To understand our position, it may be useful to take a closer look here at what is meant by cognitive services and the circumstances leading to their undervaluation. It may also be useful to examine the benefits of a more logical fee structure and a proposed plan for its implementation.

The term "cognitive services" may be less than perfect. But it has proved to be the best one for succinctly describing the processes of solving problems, applying diagnostic skills through comprehensive history-taking and physical examination, collecting and analyzing data, assessing and managing cases, counseling patients and families, and — of prime importance — providing consistent, continuing, compassionate care for patients with acute and chronic medical problems in the office, hospital, home and nursing home.

Obviously these skills transcend all specialties. But they are particularly characteristic of internal medicine. Thus, the ASIM has naturally taken the lead in seeking greater recognition of their worth.

The "thinking and caring" services have undergone a long evolution of undervaluation and undercompensation. In the beginning, before the advent of health-insurance coverage and extensive government financing of health care, physicians and patients participated equally in the setting of fees for services. This was as it should be. But, for better or for worse, the relationship changed as private and public payors became involved.

Health-insurance organizations were originally created to protect individuals from the high costs of hospitalization and later from the costs of surgery. They then expanded benefits to cover other procedural services such as laboratory tests and x-rays, again to protect the patient from high out-of-pocket expenses. They did not, however, cover the fee for cognitive services. Consequently the fee remained low, so as not to produce a serious strain on the family budget. The office visit became, in marketing terms, an unintentional "loss leader," and physicians began placing increased emphasis on performing (and charging for) ancillary procedures.

Changing the payment system, producing a different set of incentives, and maximizing rewards to all physicians for thinking, analyzing, communicating, and counseling, could help reverse historical trends and produce some welcome benefits. Logic and research tell us that reducing incentives to provide technology-intensive care will lead to fewer tests, fewer procedures, and in all probability, fewer hospitalizations. More personalized care with greater continuity should also lead to diminished physician-patient misunderstandings and conflicts, and possibly to a decrease in malpractice actions.

Furthermore, providing financial incentives for spending more time with patients will stimulate the development of better basic knowledge about and by patients concerning their present and past medical problems, their social and family histories, and their physical and mental illnesses and impairments. This practice will lead to both improved health and greater patient and physician satisfaction. Finally, tilting the incentives away from procedural services and toward cognitive services should reduce costs and induce more young physicians to seek careers in primary care.

At present, public and private payors of health care require predictable rates of their liability for payment in order to generate necessary premiums or to budget tax dollars. To this end, mechanisms were instituted to standardize compensation by setting fixed fee schedules or attempting to identify the "going rate" through the use of "usual, customary, or reasonable" (UCR) formulas.

In its beginnings, the UCR system had some advantages. But because it is essentially a charge-based system (it merely reflects what physicians have charged) it has proven to be both inflationary and inequitable. Without a doubt, both these mechanisms encourage undercompensation for cognitive services and provide powerful incentives for performing the maximum number of technical procedures on patients, a factor that all professionals want eliminated from the system.

To make matters worse, opinion leaders in both the public and private sectors perceive that charges for some physician services are not linked to actual cost or value and are, therefore, overpriced. The public, of course, has concluded that all physicians' fees are unreasonable. As a result, legislative and other "solutions" to tighten controls over physician payment are more frequently being proposed. Thus far, however, such proposals have done nothing to correct historical disparities and disincentives and are resented by physicians for their punitive and short-sighted natures.

ASIM believes that in order to solve the inequities in health-insurance and government compensation, payment should be based on the resources involved in providing each physician service. For a number of years ASIM has promoted a payment system that would base allowances on resource "costs," such as time, complexity, investment in education and training, and overhead expenses, that go into providing

a particular service. Other factors, such as risk and experience, might also be included within this definition. By comparing current allowances with identified resource costs, a rational system of payment can be created that would improve payment for undervalued services.

As early as 1979, an HCFA-funded study by two Harvard professors, William B. Stason and William C. Hsiao, concluded that a relative-value scale (RVS) based on resource costs would reduce, if not eliminate, the disparity in compensation for cognitive and procedural services. Other research also supports the validity of the resource-costs approach.

At a practical level, just over a year ago, the Massachusetts Rate Setting Commission implemented an RVS based on resource costs for the twenty-five procedures contained in the Harvard study as a basis for establishing allowances for its Medicaid and Workers' Compensation programs. The intent of incorporating this RVS into the payment system was to narrow the gap in compensation between primary care and surgical and technological procedures, and it resulted in a substantial increase in payments for office visits. However, after the new fee schedule was implemented, many Massachusetts physicians expressed strong objections to receiving reduced payment for some of the procedures, ultimately causing the Commission to restore most of the cuts, yet maintain the increased payment for office visits.

The unpopularity of the new fee schedule among some Massachusetts physicians has led skeptics to conclude that the resource-costs approach is neither practical nor desirable. The reaction to the Rate Setting Commission's actions, however, probably had less to do with the validity of the resource-costs approach than with the manner in which it was implemented.

The Commission decreed major changes in reimbursement for physician services without any direct involvement of physicians in determining appropriate relative values based on resource costs for those services. It is understandable and predictable that many physicians who were denied the opportunity to participate in the process found it difficult to accept the results. For this reason, ASIM strongly believes that all specialties of medicine must be involved in developing any future relative-value scales that might be adopted by a third party for payment purposes.

It is important to emphasize that the resource-costs approach is not an attack on the incomes of surgeons or other procedure-oriented specialists. One of a physician's most important resources is the ability to gather data, analyze it, synthesize it, and formulate appropriate solutions to problems. This talent is used in most physician activities, both inside and outside the operating room. For surgeons — and others — compensation for exercising this talent is built into the fee for the procedure. A similar measure of recognition for the use of this talent is needed where no procedure or testing is involved. It is a strange world, indeed, in which the placing of a Swan-Ganz catheter merits greater compensation than applying the ability to analyze data and determine that a procedure is needed to save a patient's life.

Fortunately, developing a relative-value scale based on resource costs is by no means an impossible task. It could be accomplished by asking a broadly representative group of physicians to use consensus-development techniques to estimate the amount of time involved, the complexity of the problem, and the knowledge, skill, experience, and other "costs" required for each physician service. Third parties could then use the RVS developed by this technique to determine allowances for payment by applying dollar amounts to each relative value. That way, the payor rather than the physician group could determine the actual fees paid.

The activity has already begun. HCFA is currently funding such a project for the Medicare program. Harvard University, with the cooperation of the American Medical Association, has contracted with HCFA to develop just such an RVS based on resource costs. And several other groups, including the Institute of Medicine of the National Academy of Sciences, are proceeding with similar studies.

ASIM, too, is proceeding with a project to collect data on the resource costs involved in providing internal medicine services (without assigning relative values) and will seek outside assistance from a university or other appropriate group. Discussions are also under way with a midwestern state society of internal medicine, a research group, and a third-party payor to undertake such a project for internal-medicine services.

In the private sector, preferred-provider organizations (PPOs) are beginning to incorporate appropriate incentives into their payment methodologies. For instance, a number of them give preferential treatment to cognitive services when establishing levels of fee discounts. Blue Cross and Blue Shield of New York recently went one step further, announcing that it was increasing allowances for in-hospital, home, and office medical care and consultations under its "Wrap Around" program in "recognition of the importance of cognitive services." Several other Blue Cross and Blue Shield plans are considering adjusting their fee schedules to favor cognitive services.

In the public sector, legislators and other influential groups are considering and supporting ASIM's approach to reforming the health-insurance payment sytem. In recent testimony before powerful Congressional health subcommittees, the AMA supported development of a resource-costs-based RVS for payment of physician services in lieu of prospective pricing based on diagnosis-related groups (DRGs). Representatives of the American Association of

Retired Persons and the American Academy of Family Physicians joined ASIM's witness in support of correcting the disparity in payment between cognitive and procedural services. Others formally supporting the concept include the American Psychiatric Association, the Joint Council on Allergy and Immunology, and several state medical associations.

Another encouraging sign that legislators are listening and considering this alternative came during the August 1985 Congressional committee discussions about extending the current across-the-board freeze on Medicare allowances. While losing in a close vote, ASIM's proposal to "thaw" the freeze on fees for certain historically undervalued primary-care services (such as office, nursing home, and home visits) received the support of several influential legislators who are looking for fair and equitable remedies to Medicare's financial problems.

One thing is increasingly obvious: there is growing Congressional support for doing something about correcting the payment disparity, and several important reports that are overdue or in progress are said to include such recommendations for the Medicare program.

Changing from a historical charge-based system to a resource-costs-based system does pose some practical problems and potential disruptions. To minimize these disruptions, such a change could be phased in by applying it first to new procedures only, with subsequent revisions as newer technologies and techniques become more widely practiced, with concomitant decreases in the costs and risks involved. Or, a new RVS could be phased in by first applying it to those services most frequently performed.

However it is implemented, the benefits of developing a resource-costs-based system of payment for physician services surely surpass not only the alternative systems, such as total capitation or global fee-per-diagnosis methodologies, but also the continuation of the current UCR inequities that have brought all physician payments under such sharp attack. Moreover, such a system would ensure maximum use of the medical services most needed and appropriate to patient needs. Using resource costs to determine fees will make the system more "technological neutral" since fees for tests or procedures will not influence the physician's income. Rather, physicians will be compensated for the application of judgment, knowledge, and skill.

Also in this process, the credibility of the medical profession as a whole will be enhanced. Without this credibility, it will be difficult to fend off stricter, shortsighted payment controls that dictate how physicians practice medicine.

Putting a rational and justifiable price tag on physician services may be a difficult and complex task, but it must be done — and done by those who provide those services. It is time for the medical profession to unite to accomplish this goal, and at the same time restore our credibility and the public's trust.

C. Burns Roehrig, M.D.
Boston, Massachusetts

Reprinted with permission from *Massachusetts Medicine*, March/April 1986, pgs. 38-41.

ADD NEW PATIENTS

A Nutrition Medical Centers franchise can help your practice grow. A logical extension of your professional knowledge and facilities, our proven system of nutrition counseling can create a new profit center for your practice. For more information on this exciting opportunity call (404) 872-4900.

NUTRITION MEDICAL CENTERS

1750 Peachtree St. N.W.
Suite 305
Atlanta, Georgia 30309
(404) 872-4900

Government Printing Office Bookstore

Jacksonville, Florida

The Government Printing Office Bookstore in Jacksonville, Florida carries in stock the International Classification of Diseases, 9th edition (ICD-9). This three-volume set contains the codes used in filing insurance claims. Price: $29.00 (paper edition) and $40.00 (cloth edition).

The book store also carries in stock four different formats of the HCFA Form 1500, used for filling out Medicare claims. The two-part carbonized snap-out form used most by doctors sells for $13.00 per 100-count package. Pre-payment is required, although there is no tax or no postage charge for 4th class mailings. Make check payable to Superintendent of Documents, or charge orders to MasterCard, Visa or Choice.

Government Printing Office Bookstore
Federal Building, Room 158
400 West Bay Street
Jacksonville, Florida
(904) 791-3801



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

This space contributed as a public service.

YOU CAN FIGHT CANCER BEFORE YOU GET IT.

OR AFTER YOU GET IT.

It's a lot easier to fight cancer before you get it.

Scientists estimate that up to 60% of all cancer could be prevented.

By simply making a few changes in your lifestyle.

By not getting too much sun. By not smoking cigarettes. By not overeating. And by following a diet high in fiber and low in fat.

By simply doing these few things, you could drastically reduce your risk of getting cancer.

Sure, you could still get cancer.

But why not give yourself the odds against it?



Help us keep winning.



To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
with acetaminophen 500 mg

Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III) Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.
Revised, April 1982.

KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

5725

February, 1985

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

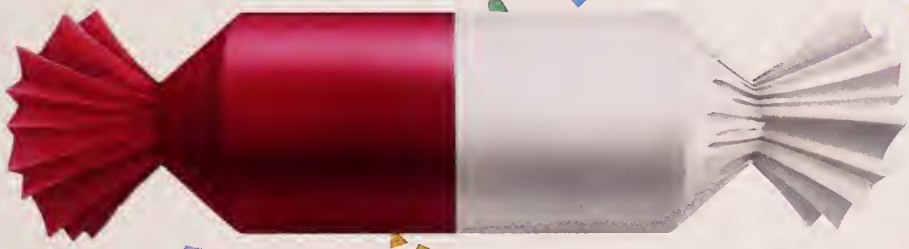
City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

10 YEARS

Thank you for your loyal support



DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

SK&F CO.

Motrin® 800 TABLETS mg

ibuprofen



Extra strength
Convenience
Economy

Upjohn
A Century of Caring
1886·1986

©1986 The Upjohn Company

J-6138 January 1986

Physiology of exercise and sport

by Bruce J. Noble. Price $27.95. C.V. Mosby Company.

Bruce Noble, in this book, "Physiology of Exercise and Sport," recounts 25 years of expertise in a field which is often dominated by chicanery and opinions not substantiated in scientific fact.

This particular book is different and it is excellent. The divisions including muscle function, metabolism, diet, pulmonary function and the physiology of exercise are well written with excellent references, tables, graphs and illustrations.

The third portion of the book dealing with training and the other parts on environment is superb from the standpoint of practical application to earlier physiologic techniques. The last portion, a treatise on special areas especially on perception, is thought provoking and a great addendum.

The glossary, index and references are the most complete of any similar treatise; all in all, the book is an excellent monograph and reference for those interested in sports, sports medicine and its applications into daily life from a scientific perspective.

On a scale of one to ten, this book deserves a ten for those interested enough to go through it and utilize it.

For the casual reader and those interested in the more mediocre approaches to the subject, which are simpler and a lot of fun rather than scientific and precise, other publications may be more to their liking.

James B. Perry, M.D.
Ft. Lauderdale

● Dr. Perry, a neurologist, is President-Elect of the Florida Medical Association.



KEY LIME PIE

"This tried and true recipe is best with a graham cracker crust. It's easy and can be done ahead!"

4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice; mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used

Mrs. Michael John Murray (Candy)
Lee County

Rx for fine dining:

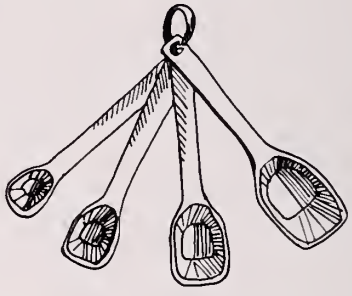
—A collection of over 700 gastronomical delights.

—Eight sections from appetizers to desserts - including many outstanding game, seafood and sauce recipes.

—Full color cover with original pen and ink illustrations dividing the sections.

—Spiral bound and indexed with menus, helpful hints and potpourri.

—Compiled by the Florida Medical Association Auxiliary for the benefit of health related projects.



Rx FOR FINE DINING
P.O. Box 2411
Jacksonville, FL 32203

Please send me ____ copies of Rx For Fine Dining at $10.00 per copy plus $1.30 for postage and handling. Florida residents add $.50 sales tax.

Make checks payable to — COOKBOOK PROJECT, FMA-A
P.O. BOX 2411
JACKSONVILLE, FL 32203

Name _____

Address _____

City, State, Zip _____

COOKBOOKS MAKE GREAT GIFTS!

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

AMA Auxiliary convention creates motivation

What a welcome and satisfying experience it was to return once again to the quiet elegance of the Drake Hotel in Chicago for the annual meeting of the American Medical Association Auxiliary! There were interesting, dynamic speakers to inform and motivate the Auxilians.

"Marketing Membership" was the first presentation. John Thompson, President of Loucks, Thompson, Starling and Associates, Inc., and faculty member of Texas Christian University, discussed reasons why people join or do not join organizations, and offered helpful suggestions and techniques for identifying weakness that can be corrected.

Mini-Briefing sessions offered a choice of AMA-A Health Projects, AMA-ERF, Legislation, and Membership. The keynote speaker, complete with secret servicemen, was the Honorable Maureen Reagan. She related her experiences representing the U.S. at worldwide meetings trying to improve the status and rights of women. She was truly a dynamic speaker, enjoyable, humorous, engrossing, and most interesting!

Resolutions adopted at the business sessions included: (1) educating the public, especially youth, about the dangers of using smokeless tobacco products; (2) education and prevention of severe injuries due to shaking a child; (3) education on reducing the risk of osteoporosis. Reports were heard from the state presidents giving an over-all view of what the Auxiliaries around the country are doing. Luncheon speakers included two well-known syndicated columnists, Rowland Evans and Robert Novak, who discussed foreign and domestic policies of the Administration. They depicted a fireside chat with their comfortable, stuffed arm chairs, and generated many questions at the close of their presentations.

The Wednesday morning closing session saw Pat Durham of Texas installed as the 1986-87 AMA Auxiliary President. Her inaugural address concerned the challenges and changes facing the medical community. The medical community has always had both, but it is our responsibility to see that changes are to the advantage of the physician and the patient. We should realize that not all change is all bad. Our task is to learn what we can or cannot change. We can no longer fit our programs only to women; we need to study program to meet the needs of all members. She urged all of us to work for tort reform as formulated by the AMA. The Auxiliary can be the driving force to protect good medical and health care. There are no guarantees for the future, but there are opportunities.

Harrison L. Rogers Jr., M.D., President of the AMA, addresed the assembly and told delegates that health care for the elderly is in serious financial trouble. The AMA has a sound program to propose for paying of Medicare, which is thought to become bankrupt in the 1990's. The liability issue is in crisis across the nation, and is growing in size. A solution is critical to the profession and the public. The cost of defensive medicine is enormous, but more important is the injection of the adversary system between doctor and patient. AMA will be looking closely at the health care issue.

The Florida Auxiliary delegates were pleased to hear Edie Epstein report on AMPAC activities, Priscilla Gerber present AMA-ERF awards, and Florida physician, Rufus Broadaway, M.D., speak as the President of the American Medical Association Education and Research Foundation.

The national convention drew to a close for another year. Auxilians and physicians headed home to aid in formulating a sound health policy for the future.

Mrs. Rex (Betty) Orr
FMA Auxiliary Delegate
St. Petersburg

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

a division of Subscription Services, Inc.

29 Glen Cove Avenue • Glen Cove, New York 11542 • 516-676-4300

Our members qualify for low professional subscription rates for magazines for office reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION	(No. of issues per yr.)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE
American Health	10	14.95	12.95	11.95
American Heritage	6	24.00	18.00	18.00
Amer.Photog.[Special:9 iss.]			7.47	7.47
Americana	6	11.95	11.95	9.95
ArtNews	12	29.95	25.95	25.95
Atlantic Monthly	12	9.95	9.95	9.95
Audio	12	17.94	8.97	8.97
AUTOMOBILE	12	24.00	12.00	
	2 yrs		22.00	
Baseball Digest	12	14.95	14.95	
for Educators: 10 issues				7.97
Basketball Digest	8	9.95	9.95	7.97
#Better Homes&Gdns	12	14.00	7.00	14.00
#BICYCLING	10	15.97	8.00	12.97
Black Enterprise	12	15.00	15.00	11.95
Boating	12	19.98	16.97	16.97
Bon Appetit	12	15.00	15.00	15.00
Boys Life	12	13.20	13.20	13.20
Car & Driver	12	16.98	11.99	11.99
Changing Times	12	15.00	9.97	9.97
#Connoisseur	12	19.95	10.00	19.95
Consumers Reports	12	16.00	16.00	16.00
#Cosmopolitan	12	24.97	15.00	24.97
Cruising World	12	18.00	18.00	14.00
Cycle	12	13.98	6.99	6.99
Cycle World	12	13.94	7.97	7.97
DISCOVER	12	23.95	13.00	14.95
Downbeat	12	18.00	18.00	9.95
EBONY	12	16.00	9.97	9.97
The Economist	52	85.00	51.00	51.00
#ELLE	12	24.00	16.00	
EM (Ebony Man)	12	24.00	19.95	19.95
ESQUIRE	12	17.94	9.95	9.95
Essence	12	12.00	9.96	9.00
Family Circle	17	14.97	9.97	
Family Computing	12	19.97	11.97	11.97
Family Handyman	10	9.95	9.95	5.95
Field & Stream	12	15.94	8.97	8.97
Fifty Plus	12	15.00	11.97	11.97
Financial World	26	41.95	24.94	
FLORIDA TREND	13	24.00	24.00	
Flying	12	18.98	15.97	15.97
Food and Wine	12	18.00	9.00	15.00
Football Digest	10	12.95	12.95	7.97
Forbes	28	42.00	42.00	28.00
Fortune	26	44.00	35.30	22.25
Games Magazine	12	15.97	15.97	15.97
Gentlemens Quartly	12	18.00	13.50	
Glamour	12	15.00	12.00	
Golf Digest	12	19.94	11.98	11.98
Golf Illus.[Special:8 issues]			5.97	5.97
Golf Magazine	12	15.94	9.97	9.97
#Good Housekeeping	12	15.97	9.97	15.97
Gourmet	12	18.00	13.50	15.00
#Harpers Bazaar	12	16.97	8.97	16.97
Harpers Magazine	12	18.00	9.97	9.97
Health [Special:9 issues]			9.97	9.97
High Fidelity	12	13.95	6.98	6.98
Home Mechanix	12	11.94	8.97	8.97
The Homeowner[Special:6 iss]			8.97	8.97
Home Viewer	12	18.00	11.97	11.97
Hot Rod	12	13.94	8.97	8.97
House and Garden	12	24.00	18.00	
#House Beautiful	12	15.97	7.99	15.97
Humpty Dumpty (4-7)	8	11.95	9.97	9.97
Inc.	12	24.00	12.00	12.00
Jerusalem Post	24	18.46	18.46	15.97
Jet	52	36.00	26.00	26.00
Ladies Home Journl	12	20.00	13.32	10.00
LIFE	12	32.50	16.25	
M (Civilized Man)	12	24.00	19.95	
Mademoiselle	12	15.00	12.00	
McCall's	12	11.95	7.95	
Metropolitan Home	12	18.00	18.00	9.00
Modern Photography	12	13.98	7.98	6.99
MONEY	12	29.95	15.00	
Mother Jones	12	24.00	16.00	16.00
Motor Trend	12	13.94	7.97	7.97
MS Magazine	12	16.00	10.97	10.97
The Nation	52	28.00	28.00	
for Educators: 24 issues				9.95
Nation's Business	12	22.00	12.97	12.97
Natural History	12	20.00	20.00	
N.E.Journal of Med.	52		60.00	
New Republic	52	48.00	48.00	28.00
N.Y. Rev of Books	17	28.00	28.00	25.95
New Woman	12	15.00	9.95	11.97
New Yorker	52	32.00	32.00	20.00
NEW SHELTER,new name:PRACTICAL HOMEOWNER				
#NEWSWEEK	52	41.00	20.80	21.85
Omni	12	24.00	15.96	15.96
1001 Home Ideas[Spec'l:8 iss]			11.97	11.97
Organic Gardening	12	12.97	9.97	9.97
Outdoor Life	12	13.94	7.97	7.97
Outside	10	16.00	12.00	8.97
Ovation	12	18.00	10.00	10.00
PARENTS	12	18.00	9.00	
Penthouse	12	36.00	30.00	30.00
People	52	56.00	56.00	28.25
Personal Computing	12	18.00	18.00	11.97
Petersens Photgrph	12	13.94	6.97	6.97
Playboy	12	25.00	21.50	21.50
#Popular Mechanics	12	13.97	7.00	13.97
Popular Photogrphy	12	11.97	5.99	5.99
Popular Science	12	13.94	7.97	7.97
#PRACT'L HOMEOWNER	9	10.97	5.50	9.97
#PREVENTION	12	13.97	7.00	13.97
PSYCHOLOGY TODAY	12	15.99	8.00	12.97
Reader's Digest	12	15.41	15.41	15.41
#Redbook	12	11.97	6.97	11.97
Road and Track	12	17.94	12.99	12.99
Robb Report	12	65.00	65.00	
The Runner [Special:8 iss.]			8.97	8.97
#RUNNER'S WORLD	12	19.95	10.00	12.97
Sail	12	21.75	21.75	21.75
Saturday Eve. Post	9	12.97	12.97	12.97
Savvy [Special:9 issues]			8.97	8.97
#Science Digest	12	13.97	6.99	13.97
Scientific Amer'n	12	24.00	24.00	24.00
Self	12	15.00	12.00	
Seventeen	12	13.95	13.95	13.95
Ski	8	11.94	6.97	6.97
Skiing	7	9.98	5.97	5.97
Skin Diver	12	13.94	7.97	7.97
SOUTHERN ACCENTS	12	18.00	16.00	
SPORT	12	12.00	7.97	7.97
Sporting News 24:6 mo		22.50	11.97	11.97
#Sports Afield	12	13.97	6.99	13.97
SPORTS ILLUSTRATED	54	58.80	34.00	29.45
Stereo Review	12	9.98	4.99	4.99
S.Porters Pers.Fin.	12	19.97	19.97	
Teen	12	12.95	7.95	7.95
Tennis	12	17.94	8.97	8.97
TIME	52	58.25	29.25	
#Town & Country	12	24.00	12.00	24.00
Travel & Leisure	12	25.00	12.50	25.00
TV Guide	52	31.20	31.20	26.00
UNIQUE HOMES	6	30.00	24.97	24.97
USA Today	260	92.00	92.00	78.00
U.S.News&World Rep	52	34.50	34.50	17.25
US Magazine	26	23.95	12.95	12.95
	2 yrs.	23.95	23.95	
Vegetarian Times	12	19.95	14.95	14.95
Video	13	12.00	8.97	8.97
Video Review	12	12.00	6.97	6.97
Village Voice	52	32.76	32.76	16.50
Vogue	12	24.00	21.00	
W Magazine	26	26.00	23.00	17.95
Weight Watchers	12	13.97	11.97	11.97
Woman's Day	17	15.13	15.13	15.13
Women's Sports	12	12.95	7.97	8.95
WORKING MOTHER	12	11.95	7.95	
Working Woman	12	18.00	12.00	15.00
World Press Review	12	16.95	16.95	14.98
World Tennis[Special:6 issues]			5.97	5.97
WORLD TRAVELING	4	11.00	9.95	9.95
Writer's Digest [Spec:9 iss.]			9.97	9.97
Yachting	12	19.98	16.97	16.97
Yankee (Colonial)	12	18.00	18.00	14.95
YM (Young Miss)	12	14.00	10.95	10.95

BUSINESS CARD NEEDED FOR OFFICE PRICE

FMA MAGAZINE PROGRAM
29 Glen Cove Avenue
Glen Cove, New York 11542

NAME _____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

Complete for Educator rates:

_____ _____
Name of Educator Affiliated Hospital / School

☐ VISA
☐ M/C No. _____ Exp. Date _____

You may pay by check or credit card. Please make checks payable to FMA Magazine Program.

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

Terms: Subscriptions are one year unless otherwise noted. Prices subject to publishers' changes.
Guarantee: Our prices are the lowest, our service the best.
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.
New Orders: Publishers take from 8 to 12 weeks to start your subscription.

FLMD786

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

AUGUST

ACLS Course, August 1-3, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Second Annual Controversies in Carcinoma of the Breast, August 6-9, Hyatt Regency, Orlando. For more info: Dr. Bramson, (813) 974-2538.

Basic Trauma Life Support, August 8-9, USF College of Medicine, Tampa. For more information: James Hillman, M.D., (813) 251-6911.

1986 Sebastian Summer Medical Symposium, August 8-10, Holiday Inn Oceanfront, Indialantic. Contact: Frank Filiberto, M.D., P.O. Box 838, Sebastian, 32958, (305) 589-3186.

Second Annual Laser Surgery Training Course, August 12-16, Wyndham Hotel, Orlando. For more information: Patti Devlin, 1414 South Kuhel Avenue, Orlando 32806-2093, (305) 841-5144.

Peruvian American Medical Society annual Medical Meeting, August 14-16, Don Cesar Beach Resort, St. Petersburg. Contact: Hugo R. Tapia, M.D., (813) 688-0576.

Annual Tips, Tricks, and Techniques in Family Medicine, August 14-17, Ponte Vedra Lodge, Ponte Vedra. Contact: Rod Gottula, MD.., 100 Royal Palm Drive, Atlantic Beach, 32233, (904) 241-5107.

Pediatric-Oriented Advanced Cardiac Life Support, August 22-24, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Strategic and Operational Survival Plans for Office Based Physicians, August 22-24, Orlando Hyatt Hotel, Orlando. For more information: Steven Mattingly, Little Creek One, Suite 202, 5808 South Rapp Street, Littleton, CO 80120.

ACLS Course (Pediatric), August 22-24, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Emergency Management of Facial, Hand and Soft Tissue Injuries, August 24-28, Ameilia Island Plantation, Amelia Island. Contact: Ira M. Dushoff, M.D., 580 West 8th Street, Jacksonville 32209, (904) 355-0561.

A Stitch in Time, August 24-28, Amelia Island Plantation Convention Center, Part I, Amelia Island. For more information: Ira M. Dushoff, M.D., 580 W. 8th Street, Jacksonville 32209, (904) 355-0561.

Pediatrics Critical Care Seminar, August 29-30, Sacred Heart Childrens Hospital, Pensacola. Contact: Reed Bell M.D., 5151 N. 9th Avenue, Pensacola, 32504 (904) 474-7724.

SEPTEMBER

Breaking the News, September 9, 1986, Doctors Hospital of Lake Worth, Lake Worth. Contact: Roberto Miguel, M.D., 2889 10th Avenue North, No. 203, Lake Worth, 33461, (305) 965-3280.

Doppler Echocardiograph Seminar, September 11-13, Innisbrook Resort, Tarpon Springs. Contact: Ann Connelly, R.N., 300 South Hawthorne Road, Winston-Salem, NC 27103.

Problems of Adolescence-Eating Disorders, September 12, 1986, West Florida Reg. Medical Center, Pensacola. Contact: Phyllis Connerly, 8383 N. Davis Highway, Pensacola, 32504, (904) 4787-4460, Ext. 4178.

Regional Scientific CME Meeting, September 12-14, 1986, Contemporary Hotel, Orlando. For more info: Eugene Schiff, M.D., VA Medical Center, 1201 N.W. 16th Street (D-1011), Miami, 33125, (305)324-3172.

Aviation Medical Seminar — For Aviation Medical Examiners, September 18-21, Doral Hotel, Miami. Contact: James L. Harris, M.Ed., P.O. Box 25082, Oklahoma City, OK 73125, (405) 686-4881.

Pharmacologic Management of the Elderly Patient, September 18-19, 1986, Gainesville Hilton, Gainesville. Contact: Dorothy R. Gagnier (904) 374-6077.

Pediatrics for the Practitioner, Sept. 19, Bay Harbor Inn, Tampa. Contact: Herbert H. Pomerance, M.D., USF Dept. of Pediatrics, 12901 N. 30th Street, Box 15CE, Tampa 33612, (813) 974-4214.

12th Annual Gulf Coast Academy Internal Medicine Conference, Sept. 19-20, Pensacola Hilton, Pensacola. Contact: Margie Rickell, 8333 North Davis Highway, Pensacola, 32523, (904) 478-4460, Ext. 4792.

New and Old Antiarrhythmic Therapy, Sept. 22, Edward White Hospital, St. Petersburg. For more information: Henry Mela Jr., M.D., 4908 First Avenue N., St. Petersburg, 33710, (813) 323-1111, Ext. 1331.

The Management of Professional in Organizations, Sept. 24-27, Peaceful Valley Lodge, Denver, Colorado. Contact: Sherry Mason, 4830 W. Kennedy Blvd., Suite 648, Tampa, 33609, (813) 873-2000.

Traumatic Spinal Cord Injury 1986, Sept. 25, Pensacola. Contact: Phyllis Connerly, 8383 N. Davis Highway, Pensacola, 32504, (904) 478-4460, Ext. 4178.

1986 Fall Conference on Pediatric Trauma, Sept. 26-27, Orlando Airport Marriott, Orlando. Contact: Patricia Brandt, P.O. Box 1393, Orlando,I 32802, (305) 244-2140.

Echocardiography 1986, Sept. 26-28, North Ridge Hospital, Ft. Lauderdale. Contact: Joseph Wanke, 5757 N. Dixie Highway, Ft. Lauderdale, 33334, (305) 776-6000.

Bereavement, Death and Dying, Sept. 26-28, Chinsegut Hill Educational Conference Center, Brooksville. Contact: Alan H. Tralins, M.D., P.O. Box 210, Clearwater, 33517-0210, (813) 462-7045.

OCTOBER

Symposium on Cardiovascular Diseases, Oct. 1-4, Marriott's Orlando World Center, Orlando. For more information: Juan J. Herran, M.D., 1414 S. Kuhl Avenue, Orlando, 32806, (305) 841-5144.

Florida Urological Society Annual Meeting, Oct. 2-4, Saddlebrook Resort, Tampa. For more info: G. Byron Hodge, M.D., (813) 974-2411.

Fourth Annual Advanced Neuroradiology Seminar, Oct. 9-11, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, 12901 N. 30th St., Tampa, 33612, (813) 974-2538.

Diagnosis & Treatment of Adult Heart Disease, Oct. 10-11,New World Landing, Pensacola. Contact: Lane Edwards, 8333 N. Davis Highway, Pensacola, 32523, (904) 478-4460, Ext. 5120.

Cardiopulmonary Update '86, Oct. 10-12, Amelia Island Plantation, Amelia Island. Contact: Alberta Hipps, 1800 Barrs Street, Jacksonville, 32203, (904) 387-7563.

Annual Health Conference of Fla. Occupation Medical Assn., Oct. 17-18, Pier 66 Hotel, Ft. Lauderdale. Contact: Richard S. Myers, 2340 S. Arlington Heights Road, Arlington Heights, IL 60005, (312) 228-6850.

The Challenge of Cancer to our Community, Oct. 17-18, St. Joseph's Hospital, Tampa. Contact: Joseph G. Sinkovics, M.D., (813) 870-4250.

Fifth Annual Medical Laboratory Immunology Symposium, October 19-22, Holiday Inn Surfside, Clearwater. Contact: Herman Friedman, Ph.D., (813) 974-3281.

1986 Family Practice Review, Oct. 22-26, Sheraton World, Orlando. Contact: William Stewart, JHMHC J-263, Gainesville, 32610, (904) 392-4321.

Arrhythmias: Interpretation, Diagnosis, and Management, Oct. 24-25, Orlando Hyatt Hotel, Orlando. For more info: Deborah Wilderson, 5808 S. Rapp Street, #202, Littleton, Co. 80120, (303) 798-9682.

Magnetic Resonance Imaging, Oct. 27-31, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

NOVEMBER

27th Workshop in Electrocardiography, Nov. 1-4, Sheraton Sand Key Resort, Clearwater Beach. For more info: Henry Marriott, M.D., 601 12th St. N., St. Petersburg, 33705, (813) 894-0790.

Internal Medicine Update, Nov. 3-7, Colony Beach & Tennis Resort, Sarasota. Contact: Murray Grossman, M.D., 750 East Adams Street, Syracuse, NY 13210, 473-4606.

Neonatal and Pediatric Respiratory Disease Conference, November 6-9, Holiday Inn Sufside, Clearwater Beach. Contact: R.L. Siegel, M.D., USF College of Medicine, 12901, N. 30th Street, Tampa 33612, (813) 972-3131.

Approach to Risk Management and Malpractice, Nov. 7-8, Sheraton Bal Harbor, Bal Harbor. For more information: Gloria Allington, Division of CME, University of Miami, P.O. Box 016960, Miami, (305) 547-6716.

Current Advances in Perinatology, Nov. 16-22, Frenchman's Reef Hotel, St. Thomas, Virgin Islands. Contact: Charles Bauer, M.D., Dept. of Pediatrics (R-131), P.O. Box 016960, Miami, 33101, (305) 547-5808.

Fourth Annual Arnold Palmer's Children's Conference, Nov. 19-22, Buena Vista Palace Hotel, Lack Buena Vista. Contact: Patricia Martinez, Dept. of Pediatrics, ORMC, 1414 South Kuhl Avenue, Orlando, 32806, (305) 841-5143.

Flexible Fiberoptic Sigmoidoscopy, Nov. 20-23, Wyndham Hotel, Orlando. For more information: Edward J. Kowalewski, M.D., 132 East 70th Street, New York, N.Y. 10021, (212) 517-7520.

Tenth Annual Seminar of the Fla. Assn. of Pediatric Tumor Programs, Nov. 20-22, Hyatt Hotel, Orlando. Contact: Cindi Butson, P.O. Box 13372, University Station, Gainesville, 32604, (904) 375-6848.

Nutrition in Pediatric Practice — 1986, Nov. 21, Bay Harbor Inn, Tampa. For more info: Herbert Pomerance, M.D., 12901 N. 30th St., Box 15CE, Tampa, 33612-4799, (813) 974-4214.

DECEMBER

Magnetic Resonance Imaging, Dec. 1-5, 1986, Dec. 8-12, 1986, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

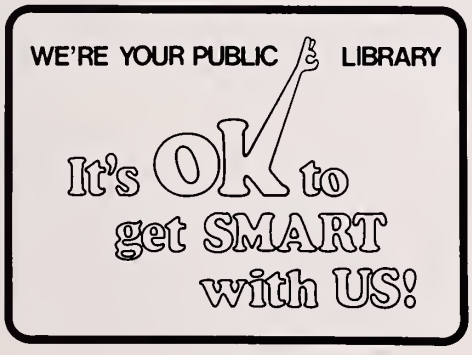
Refinements in Gastroenterologic Diagnosis, December 3-5, 1986, Contemporary Hotel, Lake Buena Vista. Contact: H. Worth Boyce Jr., M.D., USF Medical Center, Box 19, 12901 N. 30th Street, Tampa 33612, (813) 974-2034.

Workshop on Clinical Hypnosis, December 4-7, 1986, Tampa Hilton, Tampa. Contact: Alexander A. Levitan, M.D., 2051 Long Lake Road, New Brighton, Minnesota 55112, (612) 786-1620.

Vascular and Pulmonary Diseases, December 5-6, 1986, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson, 5808 S. Rapp Street, -202, Littleton, CO 80120, (303) 798-9682.

Magnetic Resonance Imaging, December 8-12, 1986, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

International Conference on Hypertension in the Elderly, December 12-16, Wyndham Hotel Sea World, Orlando. Contact: Bruce Robinson, M.D., (813) 974-2460.



Physicians' Confidential Assistance

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874 M D

THE FLORIDA MEDICAL FOUNDATION 1956

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians



When it comes to saving lives, teamwork becomes not only desirable; it becomes necessary.

In an operating room, in an emergency room, in consultation with other physicians, teamwork helps you do your job to the best of your ability.

The American Medical Association and your state and county medical societies believe in the value of teamwork — and the necessity of it, in the face of an increasingly complex professional environment.

We also believe that medical societies have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

For example, to keep government regulations from interfering with your practice, we effectively represent your interests at local and national levels.

To influence policies of organized medicine with which you disagree, we provide the means to have your views heard and respected.

And to keep you up to date on the latest medical advances, we publish JAMA, AM News, specialty, state, and county journals.

In fact, for all the times you can't operate alone, your medical societies will be there. Working with you to defend your rights and protect your freedoms.

Join Your Medical Societies Today.

For more information, contact your county or state medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name _____

Street _____

City _____ State _____ Zip _____

County _____

CLASSIFIED ADVERTISING ORDER BLANK

PLEASE PRINT OR TYPE)

Name:_____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

PRIMARY CARE CENTERS IN FLORIDA, NEW YORK, NEW JERSEY: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full time basis. Positions available in Central and South Florida coastal communities, central and northern New Jersey, and Long Island, New York area. Guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 930 South Harbor City Blvd., Suite 307, Melbourne, FL 32901.

DIAGNOSTIC RADIOLOGIST, Board Certified needed to join rapidly expanding hospital based solo-practice. Must have angiography/special procedures training/experience. Personable, willing to practice hands-on radiology. Large hospital located on the west coast of Florida, well equipped, MRI Pending. Box C-1329, P.O. Box 2411, Jacksonville, Fl. 32203.

A WEEK, A YEAR, A CAREER — Practice opportunities in Jacksonville, Miami, Orlando, Daytona Beach, Tampa. Options for permanent and/or locum tenens placements in all specialties. Trial associations with established practices in a variety of clinical settings. Call Suzanne J. Anderson at 800-833-3465 or write: Medstaff, Inc., P.O. Box 15538, Durham, NC 27704.

FAMILY PRACTICE PHYSICIANS: Opportunity for two Board Certified or Board Eligible Physicians with Florida license to join a Community Medical Practice under guidance of a recognized M.D. leader. Currently beikng developed, ideally located, the medical complex also will include laboratory, radiology and rehabilitation, in initial phases. Location on Florida's Gulf Coast in Sarasota. An attractive benefit package includes base, participation, malpractice insurance, continuing educational support, vacation, etc. Physicians interested in this professional growth potential should forward covering letter and curriculum vitae to Joseph Doney, D.H.A., P.O. Box 48926, Sarasota, FL 33578.

FAMILY PRACTICE — Orlando: Career opportunity BC/BE — Office, hospital practice in new office opening Nov. '86. Attractive financial package, guarantee, production bonuses, full insurance, share of corporation without investment. Send CV to Troy Overstreet, 120 Sunnytown Road, Casselberry, Fl. 32707, 305-339-7171.

CARDIOLOGIST: Established young BC cardiologist needs associate-partnership. BE/BC and U.S. trained. Non-invasivewith invasive potential. Miami, FL. Respond with CV to C-1339, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY, GENERAL OR INTERNAL Medicine Practitioner needed immediately for a well established, successful Family/General Practice in North Central Florida. Office has laboratory, X-ray, EKG facilities. Board Certified or eligible preferred but not necessary. Send CV to C-1307, P.O. Box 2411, Jacksonville, FL 32203.

OPENING FOR RADIOLOGIST: Diagnostic radiologist with interest and experience in mammography and ultrasound needed to staff new radiology office. Monday-Friday, 8-5. Florida License required. Salary negotiable. Contact K. Jay Adcook, M.D., 515 S. Orange Ave., Orlando, FL 32801, (305) 425-1518.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

FT. PIERCE, FLORIDA — Full time emergency department position available in a 240 bed hospital with an annual ED volume of 24,000. Candidate must be board prepared in emergency medicine. The hospital is centrally located between Disney World and Miami on Florida's Treasure Coast. Excellent compensation and malpractice insurance provided. Please send CV to Cheree Richards, EMSA, 8200 W. Sunrise Blvd., Plantation, FL 33322, or call (305 472-6922.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

ST. PETERSBURG, FL: Emergency Department physician. 42 hours per week. Nights and week-ends. Excellent compensation. Send C.V. to: Diane, P.O. Box 12077, St. Petersburg, FL 33733.

PEDIATRICIAN — multi-specialty group in East Central Mississippi with three other pediatricians. Excellent fully equipped hospital, JCAH accredited. BC/BE. Initial salary with later productivity based income. Partnership in two years. No HMO/PPO affiliations. Send CV to Kenneth J. Reid Jr., M.D., Rush Medical Group, P.A., 1314 19th Avenue, Meridian, MS 39301.

WANTED: A GENERAL SURGEON and urologist with in depth training in surgical urology and office urology to associate with D.O. on the west coast of Florida in active urological and general surgical practice. Please mail curriculum vitae with recent photograph to B. Warren Smith, D.O., 10333 Seminole Blvd., Largo, FL 33540.

CHILD AND ADOLESCENT PSYCHIATRIST. 80-100k salary. Send C.V. to: 8130 Baymeadows Circle, W., Suite 306, Jacksonville, FL 32216.

INTERNAL MEDICINE:Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

FAMILY PHYSICIAN: B.E. or B.C. for West Palm Beach practice. Florida license necessary. Opportunity for future partnership. 305-967-0234.

PHYSICIAN: Family Practitioner or Internist to associate with expanding office; Hallandale, Florida. Opportutnity to participate in new medical ventures. (305) 458-0100 or (305) 940-3533.

GENERAL INTERNIST, FAMILY PRACTICE, GERONTOLOGIST, EMERGENCY CARE MEDICINE 40 physician multi-specialty Group in West Palm Beach, Florida seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send C.V. to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 North Olive Avenue, West Palm Beach, Florida 33401.

PSYCHIATRIST — full-time position open for Board Certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient and limited inpatient on-call. Florida license needed. Reply to Box C-1349, P. O. Box 2411, Jacksonville, FL 32203.

OB/GYN PRACTICE opportunity on beautiful Amelia Island in Northeast Florida. Growth area with an established OB service and coverage available. Full service accredited hospital. Send C.V. to Alan Kent, Nassau General Hospital, 1700 E. Lime Street, Fernandina Beach, FL 32034.

INTERNIST — Internist, board certified/board eligible, wanted to join solo practice on Florida East Coast. Opportunity to step into a ready made practice with no investment and potential for full practice with in a year. Reply to Box C-1348, P. O. Box 2411, Jacksonville, FL 32203.

MULTI-SPECIALTY OPPORTUNITIES — NAPLES, FL. Expanding medical center seeks physicians in following specialties: OB/GYN, noninvasive Cardiologist, Infectiouos Diseases, Vascular Surgeon, Pediatrician, and Family Practice. Lab, x-ray, EKG, Mammo, and MRI on premises. Rapidly growing county. Send C.V. to Jerry Ruttman, Administrator, Naples Medical Center, 400 8th Street N., Naples, FL 33940.

TAMPA, FLORIDA — Excellent opportunity to become the primary physician of a well established growth oriented Family Practice in the fastest growing city in the South. Practice benefits include association with a specialty group, computerized management system, x-ray, laboratory, Spirometry, modern offices in pleasant surroundings. We are seeking a Board Certified or Board Eligible Family Practitioner, highly motivated and dedicated to the delivery of quality health care. Excellent base salary plus strong incentives based on revenues. We will provide assistance with interview and relocation expenses. If you would like to be an important part of our growing team, send your C.V. to John Q. Stauffer, M.D., 2919 Swann Avenue, Suite 205, Tampa, FL 33609; or call 813-870-3971.

PSYCHIATRISTS - Tampa Bay (1) Associate, 40K + %/fee. (2) Develop solo practice, office/services provided/fee. (3) Quality practice for sale. $100,000. Dr. P. Callahan, P. O. Box 1686, Largo, FL 34294. (813) 584-4275.

INTERNISTS — A 225 bed hospital system, in Middle Georgia and 1½ hours from Atlanta is seeking to increase their primary care base with the addition of board certified Internists. (Population 45,000, referral area 80,000). High growth area, excellent schools, and per capita income among the best in Georgia. Financial incentive negotiable. Send C.V. c/o Florida Medical Association, Box C-1345A, P. O. Box 2411, Jacksonville, FL 32203.

MEDICAL COMPLEX in the lovely Gulf Coast community of Englewood, FL (Sarasota county) seeking well-qualified physicians (general and specialty) who would be affiliated with the Venice and Englewood Community Hospitals. Phone 813-474-7772 or 2011 Englewood Rd., Englewood, FL 33533, c/o Dr. Ryan.

FAMILY PRACTITIONERS — A 225 bed hospital system, in Middle Georgia and 1½ hours from Atlanta is seeking to increase their primary care base with the addition of Family Practitioners. (Population 45,000, referral area 80,000). High growth area, excellent schools, and per capita income among the best in Georgia. Financial incentive negotiable. Send C. V. to Box C-1345B, P. O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE opportunity: established successful Family Practice opportunity for Family Practitioner in the Jacksonville area. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to Box C-1342, P. O. Box 2411, Jacksonville, FL 32203.

PHYSICIANS — Full and part-time position available in Florida (Southeast and West coast) for Board certified/eligible Emergency Medicine, Internal Medicine, and Family Practice Physicians. Competitive salary, benefits, paid malpractice insurance, and attractive scheduling. Sent CV to Emergency Medical Group, 1400 NW 12 Ave., Miami, FL 33136.

WANTED: EMERGENCY-FAMILY PRACTICE physician to staff busy walk-in clinic in Winter Haven, Florida. Salary - no overhead. Call: Dr. Gee Casebolt 813-299-8485.

FAMILY PRACTITIONER - Board Certified or Board eligible family practioner needed for established practice in beautiful West Jacksonville. Competitive salary and excellent benefits. Send CV to C. Robinson, Office Manager, 5773 Normandy Blvd., Jacksonville, FL 32205, 904-781-1866.

OPHTHALMOLOGIST — Unexpected opening for ophthalmologist in multi-specialty group on Gulf Coast to Florida. Largely F.F.S. environment in growing suburb with first year guarantee. All equipment provided. Reply to Box C-1344, P. O. Box 2411, Jacksonville, FL 32203.

FAMILY PHYSICIAN OR INTERNIST — Immediate opening to join group establishing satellite offices in Tampa area. Excellent opportunity for physician interested in private office setting with early equity in group. Send C.V. to Brad Bjornstad, M.D., 6101 Webb Road, Suite 107, Tampa, FL 33615. Phone: (813) 884-7971.

SOUTHERN GEORGIA: Emergency Department physicians needed. Full-time and part-time positions in relaxed, low volume hospitals. Flexible schedules, competitive compensation rates, professional liability insurance procured. For more information contact: Sheila Murphy, Coastal Emergency Services, Inc., P. O. Box 925, Augusta, GA 30903; collect (404) 724-3368.

NORTH CAROLINA: Emergency Department positions available throughout the scenic Blue Ridge Mountians of western North Carolina. A paradise for those who enjoy skiing, hiking, canoeing, and fishing. Easy access to major cities. Low and moderate volume facilities with good medical staff support. Excellent compensation and professioanl liability insurance procureed. Independent contractor status. For futher information contact: Ruth Bone, Coastal Emergency Services, Inc., Suite 217, Executive Park, Ashville, NC 28801; collect (704) 253-1256.

FORT LAUDERDALE, JACKSONVILLE, ORLANDO, AND SURROUNDING AREAS: Primary care physicians with Emergency Department experience wanted. Choose from metropolitan, rural, and resort locations. Competitive compensation and complete professional liability coverage. Contact: Kathy Valli, Coastal Emergency Services, Inc., (800) 328-1038 in US or (800) 432-3093 in FL; 2200 W. Commercial Blvd., Suite 203, Ft. Lauderdale, FL 33309.

EMERGENCY DEPARTMENT POSITIONS available near North Carolina's famous Pinehurst and Southern Pines golf resorts. These low to moderate volume hospitals are located with easy access to major NC cities. Competitive compensation and professional liability insurance procured. Independent contractor maintained. Contact: Marilyn Eudy, Coastal Emergency Services, Inc., Fairway Office Condominiums, Unit 115, 3623 Latrobe Dr., Charlotte, NC 28211; collect (704) 364-3252.

STATE HEALTH OFFICER — The Florida Department of Health and Rehabilitative Services seeks a highly qualified person to head the state's public health effort. This position is responsible for statewide policy direction to the state's 67 county public health units and supervision of more than 800 central office staff. The position is titled Deputy Assistant Secretary for Health and State Health Officer. It reports to the Assistant Secretary for Programs in an integrated human services delivery system. The successful candidate will be required to obtain a Florida medical or osteopathic license and must have an M.P.H. and progressive experience in public administration. Extensive public speaking and legislative representation of the agency is required. Salary is negotiable. Reply to: Marshall Kelley, Assistant Secretary for Programs, Department of Health & Rehabilitative Services, 1317 Winewood Boulevard, Tallahassee, Florida 32301 by September 15, 1986.

Situations Wanted

INTERNIST seeks to purchase established medical practice in Florida, Reply to Box C-1351, P. O. Box 2411, Jacksonville, FL 32203 or call (305) 868-6361.

VASCULAR GENERAL SURGEON, vascular surgery fellowship. Board certified, desire group practice situation in Southern Florida. Call 206-326-5891 or write S. Goff, 528 18th Ave., Seattle, WA 98122.

INTERNIST — Board Eligible, seeks position in Florida, either in hospital or with group offering opportunity for the development of procedural skills. Available the end of September, 1986. C-1343, P.O. Box 2411, Jacksonville, FL 32203.

42-YEAR-OLD, male internist-nephrologist, nine years of private practice experience, wishes to buy established internal medicine, or family practice, or to associate with a solo practitioner, or group. Other opportunities such as HMOs would be considered. Area of preference would be Broward, Palm Beach, including West Palm Beach, and Orange Counties. Other areas would also be considered. Please respond to Richard Eanni, M.D., 19 Fernandez Ave., New Windsor, New York 12550.

VASCULAR — GENERAL SURGEON -BC- Vascular fellowship, presently in private practice. Desire multi-specialty group. Reply to Box 1340, P. O. 2411, Jacksonville, FL 32203.

Practices Available

MEDICAL PRACTICE SALES. Listed are a few available practices: Allergy — large Philadelphia practice; FP & Int. Med. — two Philadelphia practices; Internal Medicine — Arizona, Bethesda, Maryland, large practice in Western Pennsylvania; Orthopedic Surgery — Western Pennsylvania; Pediatrics — Colorado, Eastern Pennsylvania and Southern New Jersey; Surgery — New Jersey. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice, contact our brokerage division at Health Care Personnel Consulting, 403 GSB Building, Bala Cynwyd, Pa. 19004, 215-667-8630.

FREE UROLOGY PRACTICE in upper Florida Keys. Introduction and support. Must be well qualified send Chief of Staff, Mariners Hospital, 50 High Point Rd., Tavernier, FL 33070.

FLORIDA WEST COAST: Splendidly located, freestanding clinic for family practice or walk-in. Laboratory and x-ray. Rapidly expanding community. Nearby accredited hospital. Annual gross over 400,000.00. C-1321, P.O. Box 2411, Jacksonville, FL 32203.

ESTABLISHED FAMILY—AVIATION MEDICINE PRACTICE, Miami, FL. Fully equipped office with assuable lease, fee-for-service, 24 hour week, good coverage and excellent growth potential. Gross in excess of $150,000. Easy terms, will introduce. Contact 36 Westward Dr., Miami Springs, FL 33166 or phone 305-888-1622.

JACKSONVILLE — FAMILY PRACTICE for sale located in the Arlington area. Physician retiring. Will sell medical office on terms-practice and equipment could be included. Once in a lifetime opportunity. For further information write or call: Broach/Shumer Realty Group, Inc., 4490 Southside Blvd., Jacksonville 32216, 904-642-6200.

UROLOGICAL PRACTICE for sale - Tampa Bay area. Urologist retiring. Available October 1986. Reply to Box C-1350, P.O. Box 2411 Jacksonville, FL 32203.

Real Estate

SPRING HILL, FL - 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease - owner will finance. (904) 596-4162 weekdays.

PRIME LOCATION for professional office rental of 1125 sq. ft. for $985.00 per month in Sarasota, FL. For further please phone 813-955-7361.

RETIRING BOARD CERTIFIED OB-GYN selling or leasing completely equipped office. Capacity for 2 or more Ob-Gyns. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone 305-667-3677.

CAYMAN ISLANDS — modern 2 bedroom beach house on Cayman Brac. Superb snorkelling and scuba. Quiet out-island setting. Rental $350.00 per week. Dr. R. Lament, 2187 West 4th Avenue, Vancouver B.C. Canada (604) 733-5722.

NEW SMYRNA BEACH, FLORIDA: Beautiful 2, 3, and 4 bedroom condominiums on the beach. Call us concerning Hospitality Suite stay. Selme Realty Inc., 305-898-0875.

SALE/LEASE MEDICAL IMAGING FACILITY, Fort Lauderdale — Building and Equipment. Turn Key. Siemens-Kodak-Technicare plus additional equipment space. 305-942-2946.

BEACH FRONT LOT, Gulf of Mexico, Little Gasparilla Island near Boca Grande. Asking $110,000, consider plane or car as partial payment. Contact W. Coyner, M.D., P. O. Box 1429, Lakeland, FL 33802.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, promptservice. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

LONG TERM FINANCING for starting or purchasing practices, diagnostic centers, equipment, office condos, buildings. $25,000 to $1,000,000. Western Financial, 1380 Miami Gardens Drive, N. Miami, Florida 33179. (305)949-5900.

ATTORNEY FOR PHYSICIANS for business, professional regulation, records, malpractice, and standard of care issues. Vitae: Doctor of Science, Health Services Administration (University of Pittsburgh); Juris Doctor, Law (Creighton University); 20 years health-care experience; Professor; publications. Licensed to practice law in Florida, Michigan, and Nebraska. Contact: Robert Woody, Attorney at Law, Suite 205, 1950 Courtney, Fort Myers, FL 33901; telephone (813) 939-4321.

WE BUY, SELL, LEASE SERVICE new and preowned medical instrumentation: Holter-Stress-Ultrasound-EKG Lab etc. Contact New Life Systems, Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065; 305-972-4600.

MEDICAL PRACTICE SALES AND APPRAISALS. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our Brokerage Division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004, 215-667-8630.

Equipment

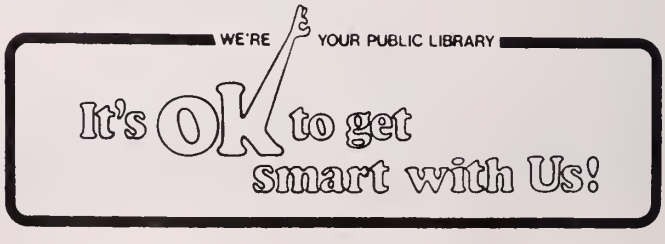
CLINITRON BED — individual selling used clinitron bed. $18,000, 904-241-8344.

SALE/LEASE MEDICAL IMAGING FACILITY, Fort Lauderdale. Building and Equipment. Turn Key. Siemens-Kodak-Technicare plus additional equipment space. 305-942-2946.

WORD PROCESSOR — SONY. Take over lease - no downpayment, series 35 partial page, dual disk drive, 55 CPS printer. 14 months on lease at $730 per quarter. Option to purchase/investment tax credit. Contact Cindy at 813-837-3332.

Meetings

CONTINUOUS WEEKLY & WEEKEND CME accredited medical/legal (risk management) seminars presented by Current Concept Seminars at: Aspen, Disney World, The Diplomat (Hollywood), Nassau, Steamboat Springs, New Orleans (Paddlewheeler cruise), Sun Valley. Fee: $185 (weekly program), $125 (weekend). For information contact Current Concept Seminars, 3301 Johnson St., Hollywood, Fl 33021, Phone 305-966-1009.



"Deafness is something you put beside you not in front of you."

LINDA BOVE / ACTRESS



PHOTO HELEN NESTOR

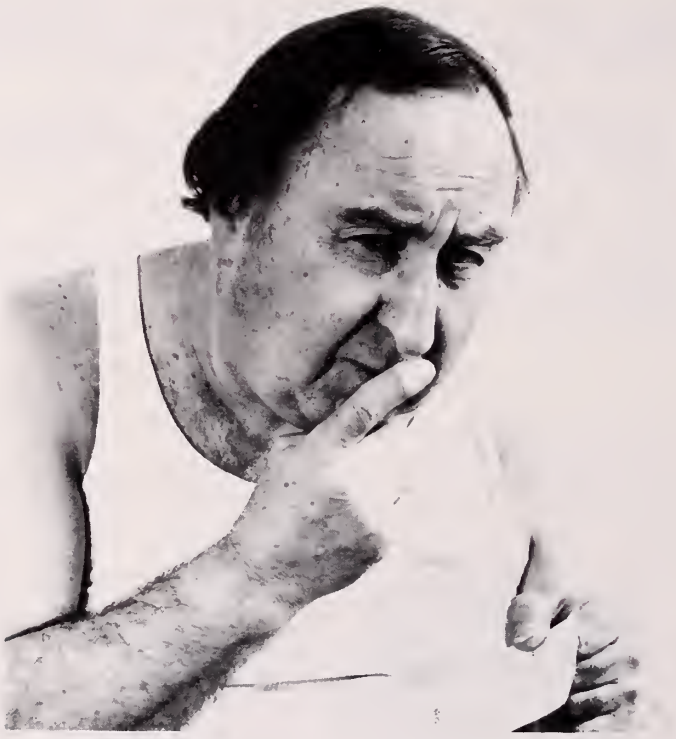
Linda Bove performed with The National Theatre of the Deaf for nine years. She has also starred in the Tony Award winning show, *Children of a Lesser God.*

Believe in them. Break the barriers.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, WASHINGTON D.C. 20210

PRODUCED BY THE SCHOOL OF VISUAL ARTS PRESS, LTD.

How well are you communicating with your PATIENTS?



Patient compliance—how well patients follow instructions about taking prescription drugs—is something that worries health professionals, according to a recent Harris survey. And with good reason. A number of studies have shown that a third to a half of all drugs are taken improperly. Yet a Chilton survey found that only 2 to 4 percent of patients question their doctors about drugs prescribed for them.

It's up to health-care providers to open up the dialogue about prescription drugs. When you write, dispense or check on a prescription, make sure your patient knows:

- **The name** of the drug
- **Its purpose**—what conditions does it treat?
- **How and when** to take the drug—and when to stop taking it
- What **food, drinks and other drugs to avoid** while taking it
- What **side effects** may result—are they serious, short-term, long-term, etc.?

■ *A message from the Food and Drug Administration.*



Her brother had Duchenne Muscular Dystrophy. Which means that though she herself is unaffected by the disease, she could be *carrying* it in her genes.

And if she is, there's a one-in-four chance her child will inherit Duchenne.

One of the most common and devastating forms of muscular dystrophy, Duchenne is usually passed from mother to child by a defective gene. The task of MDA researchers is to find that gene. And right now they're so close that MDA is pouring all possible resources into the quest.

Once the gene for Duchenne is identified, carriers can be identified, too —with 100% certainty. And the first major step toward finding a cure will have been taken.

MDA

Muscular Dystrophy Association, Jerry Lewis, National Chairman

ADVERTISERS

Academy of Neuro-Muscular Thermography
Meeting 584

Air Force
Recruitment 614

Air Force Reserves
Recruitment 630

Army Reserves
Recruitment 580

Brown Pharmaceutical
Android 581
Lipo-Nicin 641

Curtis 1000 Information Systems
Computers 642b

Eli Lilly & Company
Ceclor 578d

FMA Sponsored Insurance Plans
Service 596

Florida Physicians' Insurance Company
Service 578

Florida Power Corporation
Service 597

GTE Telenet
Service 598

Info Systems
Computers 581

Janssen Pharmaceutica
Vermox 614

Knoll Pharmaceutical Company
Vecodin 642a

Marion Laboratories, Inc.
Cardizem 578a

North Ridge General Hospital
Meeting 626

Nutrition Medical Centers
Service 641

Roche Products, Inc.
Dalmane 659
Zantac 626c

Scotland Memorial Hospital
Recruitment 630

Smith, Kline and French Company
Dyazide 578c, 642c

Southwest Florida Heart Institute
Meeting 592

Trade Winds Condominium
Real Estate 591

Upjohn Company
Motrin 642d

Willingway Hospital
Service 626

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D., Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®

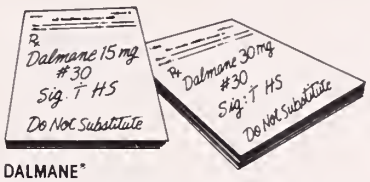
brand of
flurazepam HCl/Roche Ⓝ

sleep that satisfies

15-mg/30-mg
capsules



References: 1. Kales J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. 2. Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. 3. Kales A, *et al. Clin Pharmacol Ther 19*:576-583, May 1976. 4. Kales A, *et al. Clin Pharmacol Ther 32*:781-788, Dec 1982. 5. Frast JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. 6. Dement WC, *et al: Behav Med*, pp 25-31, Oct 1978. 7. Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. 8. Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Telecanference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
brand of
flurazepam HCl/Roche Ⓝ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see adjacent page for references and summary of product information.

DALMANE®

brand of
flurazepam HCl/Roche ℞

sleep that satisfies

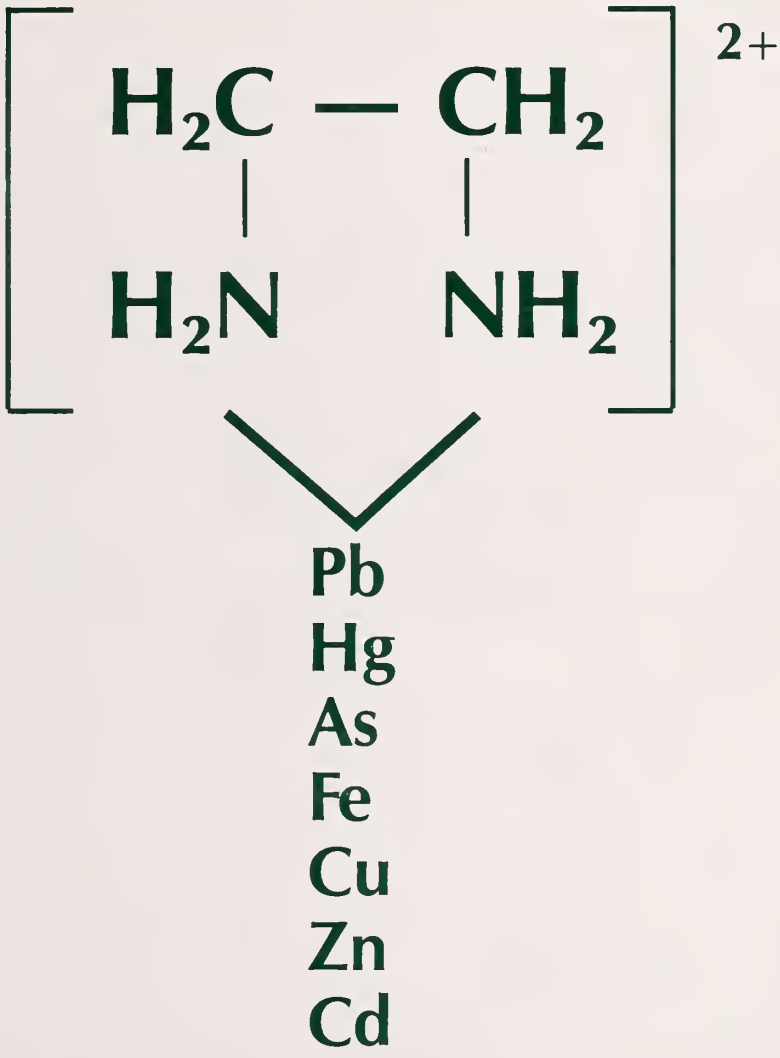


ROCHE®

Copyright © 1986 by Roche Products Inc. All rights reserved.

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. SEPTEMBER 1986, Vol. 73, No. 9

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
OCT 7 - 1986



Chelation Therapy: Science vs. Quackery

Select Quality!

The chart on this page can be used to compare the advantages of insuring with Florida Physicians Insurance Company. All medical professional liability insurance coverage is NOT the same!

QUESTION	FPIC	PPTF	ST. PAUL
Are your carrier's premiums non-assessable ?	YES	NO	YES
Is your carrier medical association sponsored ?	YES	NO	NO
Is your carrier Florida owned and operated ?	YES	YES	NO
Is the majority of your carrier's Board of Directors made up of physician's ?	YES	YES	NO

For more information call Ron Gladman:

FPIC FLORIDA PHYSICIANS INSURANCE COMPANY

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

Motrin® 800 mg TABLETS
ibuprofen



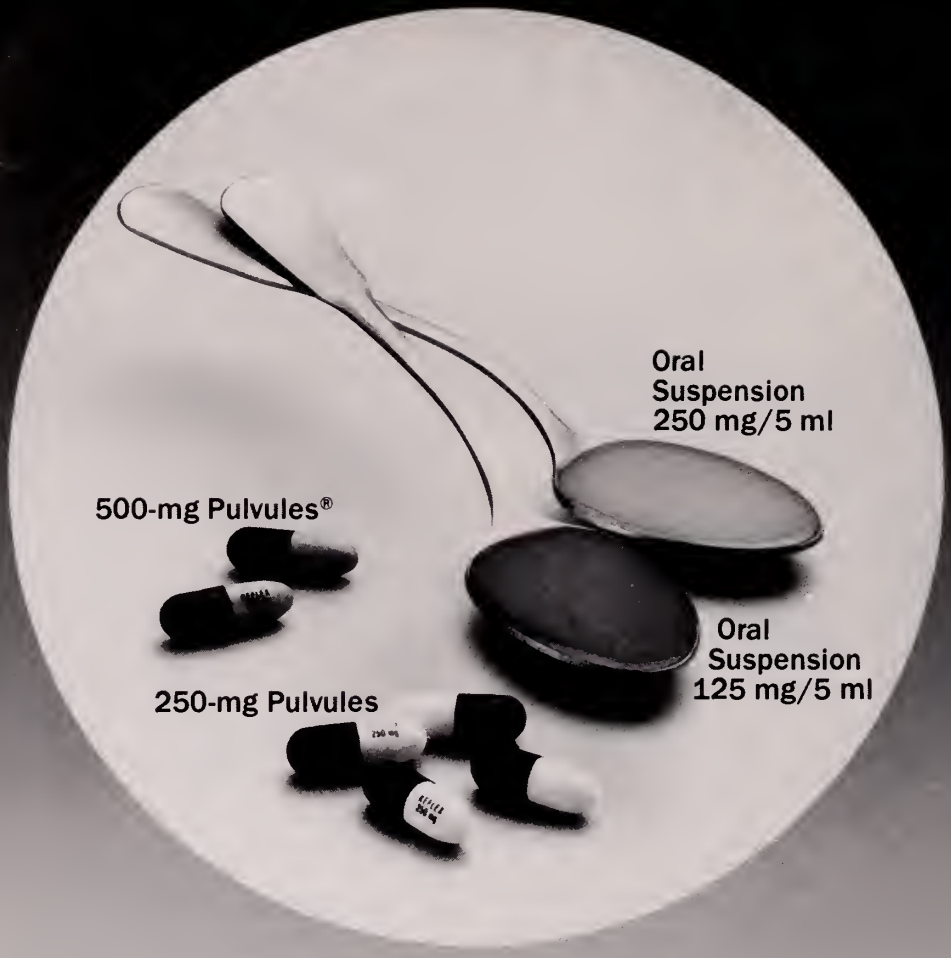
Extra strength
Convenience
Economy

Upjohn
A Century of Caring
1886·1986

©1986 The Upjohn Company

J-6138 January 1986

Easy To Take



Keflex®
cephalexin

Additional information available to the profession on request.

DISTA

420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Every day more and more physicians are hearing something remarkable from some of their hypertensive patients...




SILENCE...

from the ones on once-daily

INDERAL® LA
(PROPRANOLOL HCl)

with a side-effect profile unsurpassed by atenolol or metoprolol.

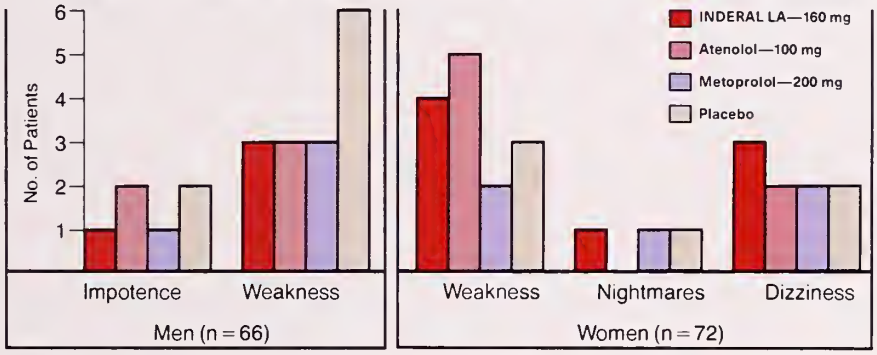
As seen in this double-blind, crossover, placebo-controlled study.[1]

Which shows you how truly well tolerated once-daily INDERAL LA can be.

What comes as *no* surprise, of course, is that it gives you the antihypertensive effectiveness you've come to expect from INDERAL.

Selected Side Effects

INDERAL LA as well tolerated as atenolol and metoprolol in a double-blind, crossover, placebo-controlled study of 138 hypertensives[1]



INDERAL® LA. For control.
Comfortable control. Once a day.
It's the last word.

Hypertensives: Feeling well and doing well, all in one.

INDERAL® LA
(PROPRANOLOL HCl)
LONG ACTING CAPSULES

or

INDERIDE® LA
(PROPRANOLOL HCl [INDERAL® LA]/ HYDROCHLOROTHIAZIDE)
LONG ACTING CAPSULES

As with all fixed-combination antihypertensives, INDERIDE LA is not indicated for the initial treatment of hypertension.

INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

Please turn page for brief summary of prescribing information.

Feeling well and doing well, all in one.

ONCE-DAILY LONG ACTING CAPSULES 80 mg 120 mg 160 mg

INDERAL® LA
(PROPRANOLOL HCl)



ONCE-DAILY LONG ACTING CAPSULES 80/50 120/50 160/50

INDERIDE® LA
Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*

INDERAL® LA Brand of PROPRANOLOL HYDROCHLORIDE **(Long Acting Capsules)**
INDERIDE® LA Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE **(Long Acting Capsules)**
INDERAL LA and INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia In patients with impaired renal function, cumulative effects of the drug may develop

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma

Thiazides may add to or potentiate the action of other antihypertensive drugs Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL Propranolol should be used with caution in patients with impaired hepatic or renal function Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that propranolol may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

PREGNANCY Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

NURSING MOTHERS Propranolol is excreted in human milk Caution should be exercised when propranolol is administered to a nursing mother

PEDIATRIC USE Safety and effectiveness in children have not been established

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance namely Hyponatremia, hypochloremic alkalosis, and hypokalemia Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids Medication such as digitalis may also influence serum electrolytes Warning signs irrespective of cause are Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH

Interference with adequate oral electrolyte intake will also contribute to hypokalemia Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening In actual salt depletion, appropriate replacement is the therapy of choice

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy

Insulin requirements in diabetic patients may be increased, decreased, or unchanged Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy

Thiazides may decrease serum PBI levels without signs of thyroid disturbance

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS Thiazide drugs may increase the responsiveness to tubocurarine

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient Thiazides may decrease arterial responsiveness to norepinephrine This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use

PREGNANCY Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult

NURSING MOTHERS Thiazides appear in human milk If use of the drug is deemed essential, the patient should stop nursing

PEDIATRIC USE Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular Bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency usually of the Raynaud type

Central Nervous System. Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place; short-term memory loss; emotional lability; slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory Bronchospasm

Hematologic Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous Alopecia. LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis, sialadenitis

Central Nervous System Dizziness, vertigo, paresthesias, headache, xanthopsia

Hematologic Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia

Cardiovascular Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions

Other Hyperglycemia, glycosuria hyperuricemia, muscle spasm; weakness, restlessness, transient blurred vision

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn

* The appearance of these capsules is a registered trademark of Ayerst Laboratories

REFERENCE:

1. Ravid M, Lang R, Jutrin I The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily *Arch Intern Med* 1985;145:1321–1323

6213/686

Ayerst AYERST LABORATORIES
New York, NY 10017

Copyright © 1986 Ayerst Laboratories



FAIR OAKS HOSPITAL
QUALITY PSYCHIATRIC CARE

Fair Oaks Hospital at Boca/Delray is a psychiatric facility that values the judgment of the referring physician. Our specialty programs are led by full-time Yale-trained psychiatrists who value and utilize the medical model.

As the referring physician, you have the opportunity to collaborate closely with our staff physicians during all phases of evaluation and treatment.

A thorough patient evaluation is conducted on the Neuropsychiatric Evaluation Unit before treatment is administered. Thorough medical, neurological and neuroendocrine testing is performed, in addition to psychological and family assessments. Individualized treatment plans are carried out by our multidisciplinary treatment teams on our Adult Psychiatric Unit, Addiction Unit and Adolescent Hospital.

The Addiction program specializes in cocaine abuse and has pioneered in new treatments for the cocaine abuser.



Fair Oaks also has a unique reference source . . . cocaine addicts themselves.



Serving as the local sponsor for the **1-800-COCAINE** National Helpline for Florida callers, we have a direct link to drug users. Fair Oaks is able to apply Helpline information in the development of treatment and research programs.

The Adolescent Hospital is under the direction of a full-time board certified child and adolescent psychiatrist and includes a full-time school program. Specialized tracks exist for adolescent patients with psychiatric and substance abuse problems. Admissions counselors are available 24 hours a day to discuss all details concerning the hospital.

For more information call or write:

Admissions Coordinator
Fair Oaks Hospital at Boca/Delray
5440 Linton Boulevard — 305/495-3737
Delray Beach, FL 33445 — 305/495-1000

FAIR OAKS
HOSPITAL
AT BOCA/DELRAY

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

SEPTEMBER 1986, Vol. 73, No. 9

CONTENTS

SCIENTIFIC ARTICLES

Mark R. Montgomery, Ph.D. **681** Advances in medical fraud: chelation therapy replaces Laetrile

Ricardo Bedoya, M.D., Sergio M. Lagman, M.D., George P. Pennington, M.D., and Amnath Kirdnual, M.D. **686** Clinical and radiological aspects of the superior mesenteric artery syndrome

Leon D. Prockop, M.D., and Allen O. Smith, M.D. **690** Seizures and action myoclonus after occupational exposure to methyl bromide

SPECIAL ARTICLES

Richard J. Feinstein, M.D. **695** Democracy and health care
Trends in three kindred western nations: Britain, Canada, and the United States

John Michael Register and Leon J. Wolfe **701** Legality of physician referral of patients to health care facilities owned by the referring physician

COVER

This month's cover of *The Journal* illustrates the chemical formula for EDPA which is a commonly used agent in chelation therapy, this month's lead Scientific Article.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.* [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc., are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Florida Medical Association, Inc.

DEPARTMENTS

667 President's Page
Warm farewell
Luis M. Perez, M.D.

671 Editorials
Language pollution in medicine
R.G. Lacsamana, M.D.
The Alamo Syndrome — is it the duty of physicians to ride to the rescue?
H. Frank Farmer, M.D., Ph.D.

677 Letters & Viewpoints

709 Notes & News

710 Dean's Message

711 Encores!

715 Book Reviews
Pensacola: Spaniards to space age
William M. Straight, M.D.

717 FMA Auxiliary
Auxilians cared in 1986
Mrs. Milton R. (Jo) Tignor

720 Meetings

724 Classified Advertising

730 Index to Advertisers

730 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

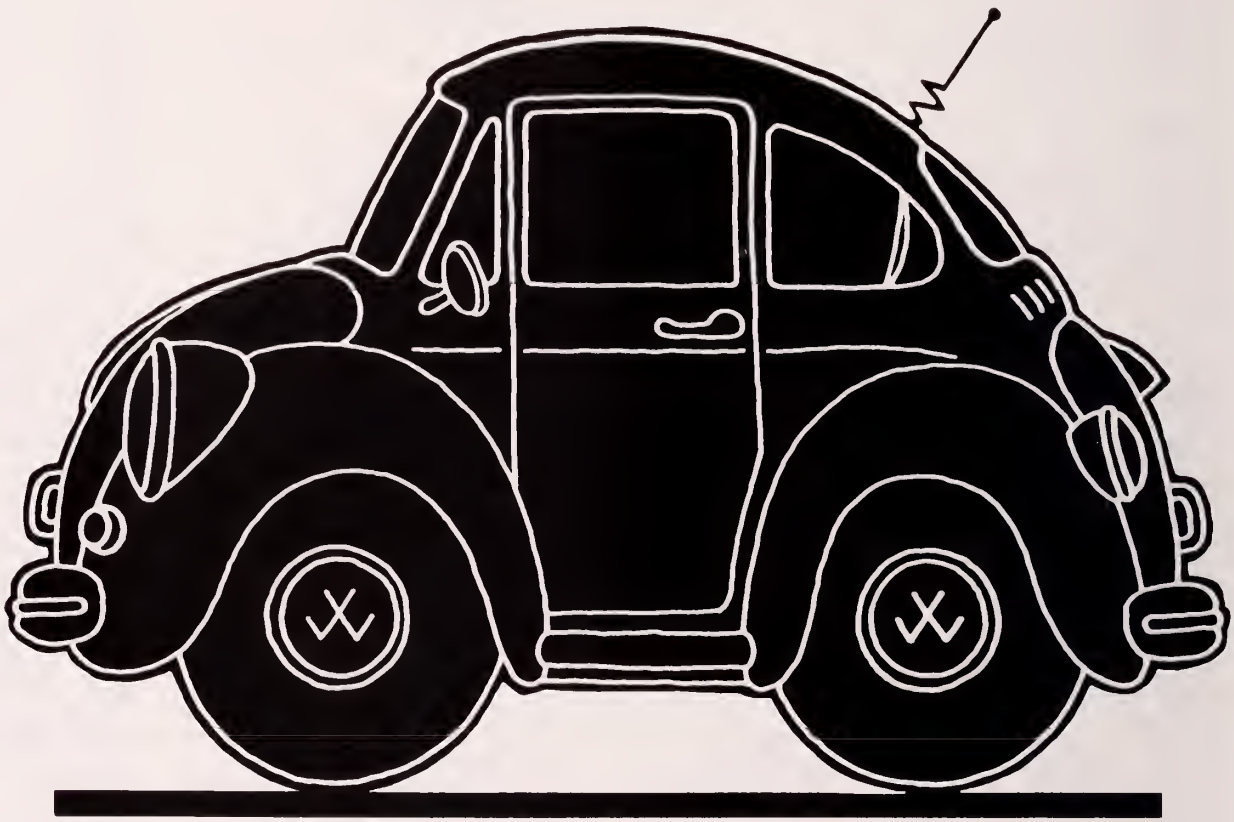
Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Karl Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Meinick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shalvitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.



Finally, A Phone For The Economy Car.

It's the BellSouth Mobility car phone. And it's now the most affordable and reliable phone on wheels–no matter what car you drive. That's why BellSouth Mobility has put more phones in more cars than anyone in the Southeast.

Our car phone is just as easy to use as the phone in your home. In fact, it's really like having another extension–only this one goes 55 miles per hour. So call BellSouth Mobility for full details today at **1-800-351-3355.** Because all the way from Jupiter to Florida City, we really are the phone company for your car.



The Phone Company For Your Car.℠

BellSouth Mobility

A *BELL*SOUTH Company

©1986 BellSouth Mobility

PRESIDENT'S PAGE

Warm farewell



This is my last President's Page in *The Journal*; by the time you read it, James B. Perry, M.D., will be your President. This has been a very rewarding year, full of big issues and controversies. The level of activity has been intense but I have been able to strengthen my friendship with a large number of colleagues and developed new ones within the medical profession as well as with individuals in other walks of life which has been very rewarding.

Through the formation of the Coalition we have been associated with several other professions and occupations. Through this coalition our horizons have been broadened and while trying to solve the problems of liability other common interests have emerged and have strengthened our association.

I would be remiss not to mention in this page the person who has encouraged me most in pursuing the aims of the Association and has given me the constant support and understanding of all the problems and anguishes during the past 16 months, Maria Perez, M.D. She has been at my side during the difficult moments of forming the Coalition, at the time of the Legislation, and has participated in my tribulations and my happiness when our efforts succeeded.

I am extremely grateful to all the members of the FMA staff, for they all responded as one to the call for action, and never shied from putting in the hours needed to accomplish the job. Donald C. Jones, the Executive Vice President, John E. Thrasher, Don Weidner, Donald S. (Scotty) Fraser, and George Palmer not only worked diligently during the whole year but, in those moments in which I was extremely tired or a little discouraged, found the way to continuously stimulate me to do the necessary job to achieve our aims.

I am also grateful to Frank C. Coleman, M.D., my predecessor, who not only taught me, and taught me well, but who continued to be available in an unconditional manner, closing gaps in my schedule and representing me.

I wish also to thank the FMA Auxiliary, who are forever present. Dynamic and motivated, they have participated intensively on all the activities of the Association throughout the year.

My thanks also go to my President-Elect, James B. Perry, M.D., who answered my calls readily and with his inexhaustive dynamism was ever-present in all the crucial moments during my tenure.

The problems of medicine are not solved. We only took one step in the right direction. We have to continue the process of being involved politically in this election and continue in the next legislation to obtain the $250,000 cap on general damages.

The seed we planted this year in the Legislature concerning the problem of treating the medically indigent and the elderly will probably be fruitful next year and will have to be addressed.

The problem of AIDS, which is threatening the nation with a real epidemic, has to be a serious concern of every physician in the State of Florida. Along with the AIDS epidemic, the increasing drug abuse, especially involving our youth, is an issue that we are going to have to hit head on; we must participate actively in the solutions.

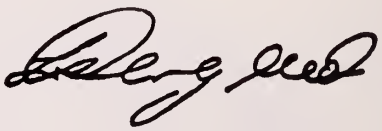
At the national level, the problems with HMOs, IPAs, PPAs, PPOs, etc., and the problems with Medicare have to be addressed with more dynamic forces and innovative ideas. Our efforts at the state

and national level have to be intensified in the very near future.

In leaving the Presidency, I am confronted with mixed emotions. It is a relief that after 16 hard months I can go back to my office on a regular basis and again practice medicine as usual, being able to participate again in the activities in my town and my community. At the same time the feeling of nostalgia cannot be avoided because after 16 months of febrile activity and constant challenges a slight sensation of emptiness will be felt.

I believe that this year I am leaving your Association more united and stronger than ever. Inroads have been made that cannot take us anywhere else but to a successful completion of our desires and fulfillments of our needs.

I thank you for the privilege and the honor that you vested upon me when you elected me your President. The thing to do now is to continue to be united, all of us behind our new President, giving him all the support possible that he deserves, for the betterment of the medical profession and the State of Florida.



FAMILY PRACTICE. A REWARDING EXPERIENCE IN ARMY MEDICINE.



THE ARMY RESERVE IN THE SOUTHEAST NEEDS PHYSICIANS WHO SPECIALIZE IN FAMILY PRACTICE, TO JOIN AN EXCEPTIONAL TEAM.

WE UNDERSTAND THE DEMANDS ON A BUSY PRACTITIONER. SO WE'RE FLEXIBLE ABOUT TIME, PARTICULARLY WHEN IT'S TIME YOU WANT TO SHARE WITH YOUR COUNTRY.

IN THE ARMY RESERVE, YOU'LL FIND OPPORTUNITIES THAT ARE CHALLENGING AND VARIED. OPPORTUNITIES TO PARTICIPATE IN EXCITING TRAINING PROGRAMS AND WORK WITH OUTSTANDING PHYSICIANS FROM EVERY AREA OF THE COUNTRY AND TO EXTEND ASPECTS OF YOUR SPECIALITY. WE THINK A FIRST PHONE CALL COULD PROVE TO BE REWARDING.

THE ACTIVE ARMY HAS MORE SOLDIERS WITH FAMILIES THAN EVER BEFORE. SO WHEN YOU JOIN THE ARMY MEDICAL TEAM AS A FAMILY PRACTITIONER, EXPECT TO SPEND MOST OF YOUR TIME SERVING NOT ONLY SOLDIERS, BUT THEIR SPOUSES AND CHILDREN, TOO. WHAT'S MORE, YOU WON'T HAVE TO WORRY ABOUT THE PAPERWORK, MALPRACTICE INSURANCE PREMIUMS, OR THE COSTS INCURRED IN RUNNING A PRIVATE PRACTICE.

WORKING WITH A TEAM OF HIGHLY TRAINED PROFESSIONALS, YOU CAN RECEIVE ASSIGNMENTS ALMOST ANYWHERE IN THE U.S. AS WELL AS OVERSEAS. PLUS UP TO 30 DAYS OF PAID VACATION AND REASONABLE WORK HOURS.

ALL IN ALL, YOUR ARMY FAMILY PRACTICE WILL BE A REWARDING EXPERIENCE.

TALK TO YOUR LOCAL U.S. ARMY OR ARMY RESERVE MEDICAL DEPARTMENT COUNSELOR FOR MORE INFORMATION ON FAMILY PRACTICE IN THE ARMY.

ARMY/ARMY RESERVE MEDICINE
3101 MAGUIRE BLVD
ESSEX BLD, SUITE 166
ORLANDO, FL 32803
CALL COLLECT: (305) 896-0780

ARMY. ARMY RESERVE. BE ALL YOU CAN BE.

FAMILY PHYSICIANS—GENERAL SURGEONS—INTERNISTS

Why, How and When?

Flexible Sigmoidoscopy

A 1½ day postgraduate course and workshop

- *ACCREDITATION:* Approved for 10½ hrs. credit: Category 1, AMA and Prescribed credit AAFP
- SPONSOR: Medical Education Foundation of Miami
- CO-SPONSORS: South Miami Hospital, Florida Gastroenterologic Society
- COURSE DIRECTOR: John P. Christie, M.D.
- REGISTRATION FEE: $225.00 (Syllabus and luncheon included)

Sat./Sun., Nov. 15-16, 1986

The Sonesta Beach Hotel and Tennis Club, Key Biscayne, Fla.

For information, write to:
6614 Miami Lakes Drive East
Miami Lakes, Florida
(305) 687-1367

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg Buccal/10 mg Oral/25 mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg





Language pollution in medicine

There ought to be a law to prohibit the use of gobbledygook in medicine and to preserve the dignity of the profession. If Miss Thistlebottom can insist on the use of proper English in her classroom, so should we in medicine.

My hackles were raised long ago when government bureaucrats and self-appointed experts, for whatever reason, began referring to medicine as the health care industry. There is absolutely nothing edifying about this term; apart from its ugly connotation, it is a poor substitute for a profession whose very essence is antithetical to that of an industry. Perhaps I am just being overly sensitive, but then nobody ever refers to universities as learning factories, the ministry as the pulpit business, or journalism as the news-peddling trade.

The late George Orwell recognized the manipulation of language as one way to collectivize the thinking of people and to dupe them to an ideology. Marshall McLuhan said as much in his famous treatise on the medium as the message. In medicine, the worst Orwellian scenario has been taking place for sometime, with but a faint protest from physicians. Having succeeded in calling the medical profession an industry, the same bureaucrats trying to mold medicine into their image have found it easy to refer to physicians as health care providers, and to describe patients (poor patients!) as nothing but consumers.

As providers, we do not render services but deliver a product. As consumers, patients visit their doctors, er, their health care providers, for cost-effective transactions (and perhaps to get well). The physician-patient relationship, once a sacred trust, has become but a casual encounter, something akin to a stock broker selling a portfolio to his favorite client.

The image manipulators have caught us with our pants down, and so the infusion of bureaucratese into the lexicon of medicine continues, not in a trickle, but in a flood. Such terms as bottom line, profit motive, entrepreneur, medical-industrial complex, doc-in-the-box, franchise medicine, quality assurance, cost constraints, and a host of other beguiling catch-words and phrases have become enshrined in the physician's vocabulary as much as, for example, menopause, libido, and endoscopy. And I see no end in sight for this language pollution.

The people from above pulling the strings on medicine of course know what they are doing. They have a job to do: to cut the costs of medical care; and to do it well, they have to project the image of medicine as a big industry, with a balance sheet, providers, entrepreneurs, and consumers. It is much easier regulating an industry than a profession, and much more expedient dealing with providers and consumers than with physicians and patients.

To say that we have lost the battle to the bureaucrats may be an understatement , but I think we need to scream in protest against this orgy of iconoclasm that is destroying the traditional image of our profession. My objections to the new bureaucratic language in medicine are rooted not only along semantic lines (there is no beauty or grace to the words), but on the premise that once having controlled the language, the same bureaucrats will control everything else, which, in fact, is what is happening.

The loudest whimper I have read about from physicians was at the last AMA annual session where primary care physicians vociferously objected to being called gatekeepers. Although they struck down the word, they nevertheless endorsed the concept, which sounds like doubletalk to me. But I am just glad I am not a pathologist: I would hate to be called a gravedigger!

R.G. Lacsamana, M.D.
Editor

The Alamo Syndrome — is it the duty of physicians to ride to the rescue?

Recently, several events have occurred at the tax-supported community hospital where I practice to cause me to reflect on a previous historical event, the gallant stand at the Alamo in 1836 when 182 Texans fought the Mexican Army to a standstill for 13 days. It was brutal fighting with the Texans giving up every foot of soil at a terrible price to the Mexicans. But give it up they did as the overwhelming force of the Mexican troops gained the mission bit by bit until at last the Texans were holed up in the chapel trying to take a few more of Santa Ana's soldiers with them to the final judgment.

What in the world has happened in a hospital which would remind me of the Alamo? Like most community hospitals, it has faced a new and bewildering experience over the past few years. It has had to reconcile its role in the care of patients which has changed drastically over the past decade. The hospital has metamorphosed from an institution that had a seemingly endless clientele to one of declining occupancy and deficits. I have heard and read that much of the same thing is happening in other hospitals across the nation. On the other hand, there are hospitals which are surviving and prospering in these changing times. Over the past year I have seen the census continue to drop as more and more measures are taken to offset the continuing hemorrhage of red ink. The efforts to offset the increasing deficits has included closing of beds, a freeze on hiring personnel and encouraging nurses to take days off without pay. The closing of beds had been expanded to include an entire floor which seemed to stabilize things for a period of time. Suddenly, over the past few months, the situation has worsened. In a hospital with over 110 beds, there would be less than 30 patients at times. The periods when the census was disastrously low seemed to become the norm and precipitated more stringent measures, including the closing of another floor and a reduction of beds in the intensive care unit.

I was contemplating all of these things as I walked up to the hospital recently to make rounds on the fourth floor, the only floor on the hospital still open for patient care, not counting the obstetrical ward. It was quite a sight as the elevator stopped at all the previously used floors which now resembled tombs with empty nurses' stations, chart racks and an occasional IV pole to give a pointed reminder that once upon a time there were patients, doctors and nurses busily carrying out the business of medicine. I was suddenly struck by the analogy of the Texans at the Alamo as I surveyed the remnants of a hospital. I could almost see the Texans defending one wall, then abandon it and try to reassemble their defenses at another area. I could sense the clash of arms, the roar of the cannon, the cry of the wounded as I saw nurses transfer patients from one abandoned floor to another, being careful to carry what could be used in an economic and utilitarian manner on the next floor. There would once again be a gallant display of bravery, stiff upper lips and a can-do attitude for a brief period of time. However, soon there would be another order to abandon the floor and retreat to another enclave.

As I got off the elevator at the fourth floor, I realized that we were, figuratively, at the chapel in the Alamo. This was it. There was no place left to go. The hospital only has four stories. If any further retreat is sounded, I suppose we can set up an outpost on the roof and try to hold on for a few more days. As I looked around me I could see the look of fatigue and strain on the hospital personnel — withstanding a siege is hard and exhausting work. When would the next memo come down suggesting that more days off without pay be taken?

The analogy was complete when the dietary department put out a memo that due to budgetary constraints, the number of entrees served in the employee cafeteria would be reduced and soup and sandwiches would be served more frequently. Notwithstanding that the change in fare may be more welcomed to the staff than what was previously served, it struck me that the reductions of rations symbolize defenders of all sieges as they tightened their belts and stubbornly stood their ground, awaiting for the final assault.

As I mused on all the events of the past few months, I have asked myself the question: is it the ethical or moral responsibilities of doctors to become involved in the running of a hospital, to the degree of pointing out to the governing authority what changes could be instituted to try to save a floundering hospital? Over the past few years, physicians have been told that it is part of their responsibility to see that patients are treated not only in a medically proper manner, but also in an economically proper manner. Proper, in this sense, means that the hospital makes money on the patient, or at least does not lose money. The physicians who treat their patients for less than the DRG reimbursement have acted in an economically proper manner, as reflected on the ledger sheet.

These events have come to pass in the last three years and represent a radical change in the physician's role in the hospital. Traditionally, the hospital was an extension of the physician's office and, more often than not, the physician did not feel an obligation to guard the financial status of the hospital. In addition he also did not feel that the administration of a hospital was part of his privy. These feelings were not as a result of selfishness, but because physicians were not expected, and did not wish, to become involved either in the finances or the administration of a hospital. However, as events transpired and it was seen that finances for health care were finite and competitive, the physicians have been held at least partially responsible for the financial stability of hospitals.

Physicians have accepted this unfamiliar task and responsibility with remarkable results. Most experts on the matter would agree that in hospitals across the country, the record of physicians has been excellent in streamlining their admissions and medical practices for the financial good of the hospitals. However, physicians have been hesitant to speak out on matters concerning the management of the hospital in which they practice. Ironically, we have been held responsible for the solvency of hospitals to some degree, but have yet not grasped the full implications of this concept.

If it is the ethical and moral responsibility to watch out for the economic survivability in one sphere, why is it not a moral duty to extend that into the administration of a hospital?

Obviously, we cannot run the hospital or dictate completely the course of a governing board, but we can and should influence that governing body. It is the responsibility of every physician on a hospital staff to ensure that his hospital is being run as best it can. This means learning something about hospital administration, budgets, etc., and then insisting that the views of physicians be presented to the governing body whether it is an appointed or elected board. Doctors also have the responsibility of seeing that this is not a perfunctory exercise. This will not be an easy task because administrators have not yet had to take into account a well-informed and interested physician's presence.

In this day of struggling hospitals and changing economic times, it is imperative that physicians let governing bodies and administrators know that we are going to be intimately involved in the affairs of our respective hospitals. I suppose it is easier to do this in a tax-supported institution in which taxpayers, which physicians are, have the right to demand an accounting of tax-supported dollars. However, physicians in private hospitals also carry a significant amount of clout and should insist on being heard.

There is no one more concerned about the survivability of hospitals than the physicians who practice in those hospitals. Throw off the shackles and embrace this concept to its fullest. Hold the hospital administrators and governing body as accountable for the economic viability of the hospitals as they have held us for the past three years.

Not all hospitals which are floundering are poorly run, but it behooves all physicians to make sure that a hospital that is floundering is not because it is poorly run. We must never forget that we are an intelligent, energetic group, and if anyone is qualified by temperament, self-interest and concern for the patients to limit the number of Alamo-like situations in our hospitals, it is us.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor
New Smyrna Beach

YOUR NEW LOW DAILY RATES AT AVIS START AT $33.00



Avis features GM cars. Buick Century.

Your association membership means new, uniform low flat rates at Avis. And there's no charge for mileage. Choose from subcompact through full size 4-door car groups:

DAILY RATE	
SUBCOMPACT (Chevrolet Chevette or similar)	**$33.00**
FULL SIZE 2-DOOR (Buick Century or similar)	**$39.00**

These uniform low flat rates make it easy to know your rate before you go. To reserve a car, call Avis toll free: ***1-800-331-1212***

Be sure to mention your Avis Worldwide Discount number: **A/A616900.**

AVIS® ***WE TRY HARDER.®***

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. Flat rates are nondiscountable and are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. An additional charge per day will apply in certain locations including Newark Airport, NJ; LaGuardia Airport, NY; Kennedy Airport, NY; and all Manhattan locations. Check with Avis for the amount. Rates, discounts and additional charges subject to change without notice. Cars must be returned to rental location or higher daily rate and a one-way service fee will apply. Cars and particular car groups subject to availability. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

© 1985 Avis Rent A Car System, Inc., Avis®

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC. P.O. BOX 2411, JACKSONVILLE, FL 32203 TELEPHONE 904/356-1571

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

ANATOMY OF MEDICAL MALPRACTICE AND RISK MANAGEMENT

Saturday and Sunday
October 4 & 5, 1986

ACCREDITATION: Applied for:
17 hours Category I credit —- AMA
16 CEUs — Florida State Board of Nursing
17 CLE hours — The Florida Bar

Under FL HB1352, it is now a requirement that every physician must take at least 5 hours of medical risk management education every two years. This course will qualify for that provision.

University of Miami
•
JAMES L. KNIGHT CENTER
MIAMI, FLORIDA
•
HOTEL ACCOMMODATIONS:
HYATT REGENCY MIAMI

SPONSOR:
AMERICAN INSTITUTE OF MEDICAL LAW, INC.

FACULTY

Edward R. Annis, M.D.
Miami, FL

Charles Baggett, A.R.M.
Miami, FL

M. P. Demos, M.D., J.D.
Miami, FL

Charlotte Dison, R.N.
Miami, FL

Roberta Fox, FL State Senator
Miami, FL

Linda Fenner, Esq.
Miami, FL

Charles K. George, Esq.
Miami, FL

Ruth Hamlin, R.N.
Miami, FL

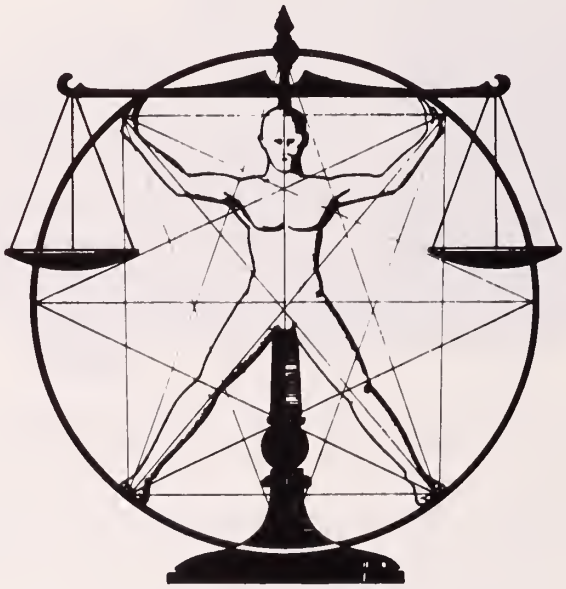
Frederick E. Hasty, III, Esq.
Miami, FL

Dale Hazlett, Director, Dept. of Insurance
Tallahassee, FL

Frank Jackalone, Lobbyist
Ft. Lauderdale, FL

Jonathan P. Lynn, Esq.
Miami, FL

Victor Martinez, M.D.
Tampa, FL



W. G. McCue, Jr., FL Association of Insurance Agents
Tallahassee, FL

Betty Metcalf, FL State Representative
Miami, FL

Joseph P. Metzger, Esq.
West Palm Beach, FL

R. B. Moore, M.D.
West Palm Beach, FL

Harold Norman, M.D.
Miami, FL

Morris Proenza, Esq.
Miami, FL

Murray Sams, Jr., Esq.
Miami, FL

Christian D. Searcy, Esq.
West Palm Beach, FL

Linda Simunek, R.N., PhD., J.D.
Miami, FL

J. B. Spence, Esq.
Miami, FL

Carl P. Stephens, Esq.
Miami, FL

Larry S. Stewart, Esq.
Miami, FL

A SEMINAR ON THE CAUSES AND TREATMENT by NATIONALLY RECOGNIZED ATTORNEYS AND PHYSICIANS

REGISTRATION FORM

NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

PHONE _____

Specialty: _____

If spouse accompanying, first name: _____

REGISTRATION FEE: $295.00 (includes Continental Breakfast and Luncheon Each Day).

☐ REGISTRATION FEE
(PHYSICIANS & ATTORNEYS) $295.00

☐ REGISTRATION FEE
(NURSES, MEDICAL, INSURANCE, LEGAL PERSONNEL AND GUESTS) $195.00

☐ SEND COMPLETE BROCHURE

Please make check payable (in U.S. Dollars) to:

AMERICAN INSTITUTE OF MEDICAL LAW, INC.

Detach and mail to:

6614 Miami Lakes Drive East, Miami Lakes, FL 33014

In defense of peer review

This is in response to W. E. Manry Jr., M.D., of Lake Wales, in the July 1986 issue of *The Journal* concerning his proposed letter to Medicare patients.

As a member of the board of trustees for the Florida State Peer Review Organization and as a physician reviewer, I take a little offense to some of the statements that Dr. Manry included in his letter.

The third paragraph of his letter makes an attempt to define a "true peer review" as one which would ". . . involve chart evaluation by physicians experienced in a comparable practice in a similar area, who would evaluate sincerely and objectively, and with humility and insight, that care that a patient receives in the hospital, considering all of the circumstances requiring such care, and the evident medical expertise of the attending physician, and his documentation."

I feel that Dr. Manry is not aware of how close the actual review process is to his definition.

As an ophthalmologist, I review charts of other ophthalmologists throughout the state of Florida. Fortunately the practice of ophthalmology in Florida does not differ greatly from one region to another. There are, however, other physician reviewers in other parts of the state. Once a patient's record has been screened by a nurse reviewer, it will end up on my desk for further review. I begin with a set of guidelines related to my specialty which have been distributed to all physicians. I then review "the care that the patient received in the hospital." Rest assured, I do "consider all the circumstances requiring such care." I would try to "evaluate sincerely and objectively, and with humility and insight" in every case. If there is any question, the physician is contacted by phone, depending on whether he or she will answer or return my calls. If there are any reasonable doubts, my decision always sides with the patient and his or her care. I constantly try to put myself in the reviewed physician's situation.

I only wish that the "evident medical expertise of the attending physician, and his documentation" occurred at the same time. It is usually the lack of documentation that makes the review of most patients' records extremely difficult. It is difficult to approve an admission for a patient with "severe hypertension" or "severe diabetes" when the blood pressure was taken only once at admission and was found to be within normal limits, or when blood sugars were never obtained and the patient is given a regular diet.

Your example of the 88-year-old gentleman with a fractured knee cap is unfortunate. However, the guidelines given to us, the reviewers, are quite specific when it comes to "custodial or social care." As a physician, I feel exactly the same way as you do when these situations arise. My charts are scrutinized in the same way that yours are.

The criteria may, at times, seem "unreasonable" but the "judgment of the attending physician" is never left unnoticed. This is the reason that we have reconsideration and appeal processes even with PRO denials.

The system is certainly not perfect, but then again neither is the practice of medicine. We are constantly improving and changing admission criteria to meet the needs of the physician and patient and still stay within certain guidelines. Your "proposed letter" does help make the patient aware that there is a "system" that is now in effect and has been in effect for a couple of years. I just hope that your patients do not feel

that every physician reviewer and member of the PRO is always "out to get them." This would certainly be a misrepresentation of the actual fact.

Charles B. Slonim, M.D.
Member, Board of Trustees
State of Florida PRO
Professional Foundation for Health Care
Tampa

Author's reply: No real problem with the physician reviewers. The ones I have talked with were sincere and empathetic sounding. My unhappiness is only with the limitations they must work under.

They are required to view each case under two major criteria: 1. Validity of circumstances requiring admission; 2. Intensity of care after admission, with specified parameters in each category of illness.

These two major criteria must both be fully and separately satisfied. Even if an admission was clearly unavoidable, if the subsequent management of the patient involves less intensity of care than the guidelines, the physician reviewer must say so, and that automatically throws out the case, even if the reviewer sees that the patient was properly handled.

Surely somebody in the chain of command has misinterpreted the guidelines handed down.

The fact that I had to admit a patient should not mean that I must then overtreat him just to get past the PRO review. I refuse to be that unethical and dishonest.

The intensity of care criterion should be only a guideline to fall back on if the circumstances of admission leave some doubt.

As a 14-year-member of the State Peer Medical Utilization Review Committee, my heart goes out to Dr. Slonim and his colleagúes. I am agitating only to give them realistic guidelines, and then allow them to function as true peer reviewers in this unpleasant but necessary activity.

W. E. Manry Jr., M.D.
Lake Wales

High-tech medicine

Compliments for reprinting Dr. Curtis E. Margo's article "Selling Surgery" in your July issue.

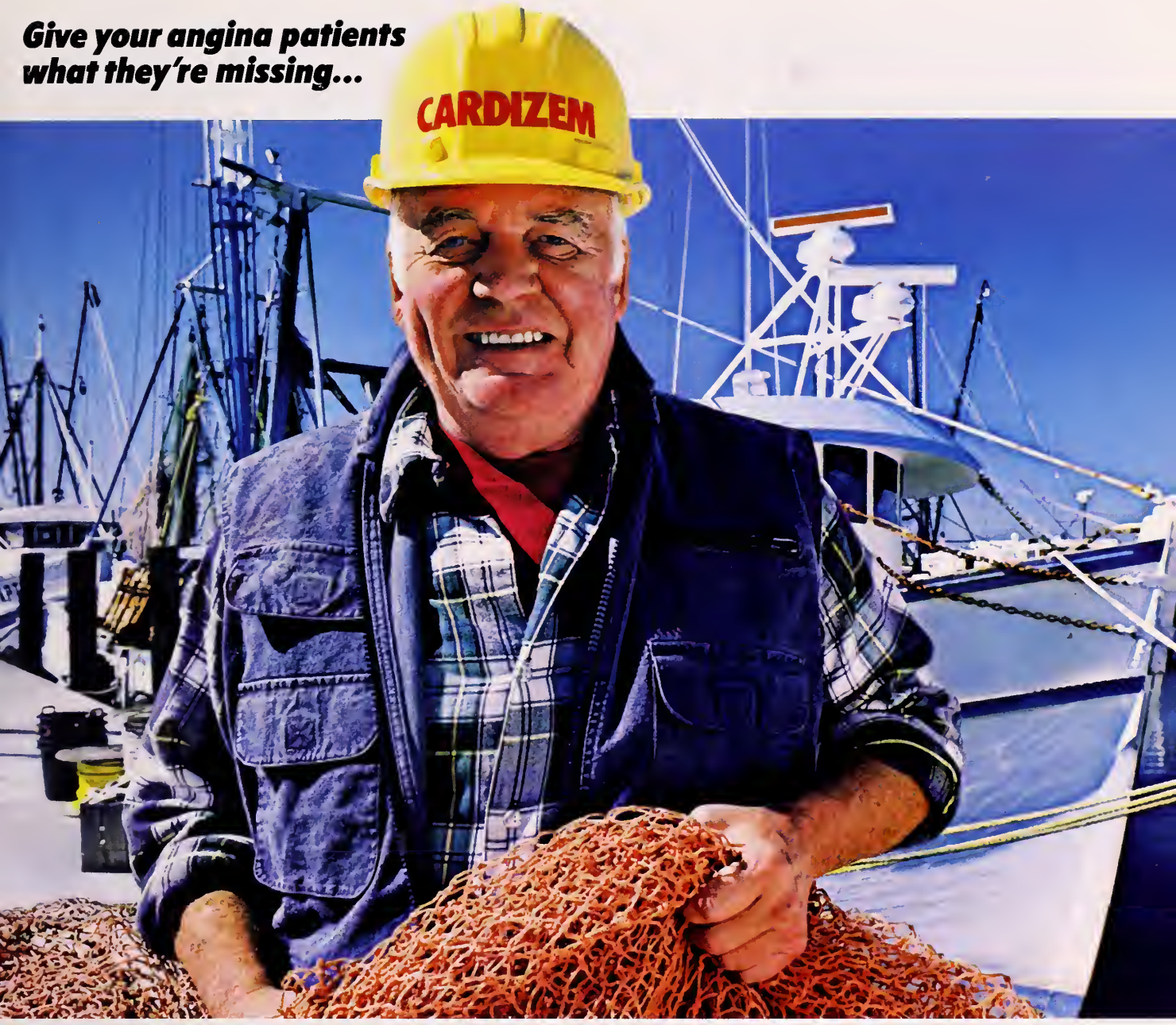
This article is very well written and can apply to a variety of procedures in any of the specialties or subspecialties.

For example: in Orthopaedic Surgery, substitute arthroscopy for cataract surgery.

Merlin G. Anderson, M.D.
Tampa

Editor's Note: Dr. Margo has indeed written a thoughtful article that should make all physicians reflect on some aspects of current medical practice. The practices that he condemns, particularly the high-pressured pitches for certain procedures, are bound to leave a bad taste in the mouth for both patients and the government.

Give your angina patients what they're missing...



CARDIZEM®: FEW SIDE EFFECTS

diltiazem HCl/Marion

- ***Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate***
- ***Proven efficacy when used alone in angina[1]***
- ***Compatible with other antianginals[2,3]****
- ***A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD[4,5]***

***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.



CARDIZEM® FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

diltiazem HCl/Marion

60 mg tid or qid

Brief Summary
Professional Use Information
CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets
CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).
WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 11/85*
See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159.* ***3.*** *Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS. Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137

0088M6

How To Keep Your Electronic Equipment From Feeling Down And Out.



WHEN STORMY WEATHER STRIKES, SENSITIVE ELECTRONIC EQUIPMENT SUFFERS.

Thunderstorms, surges and split-second voltage changes can cost you lost data. Output errors. Even damaged hardware...unless you get protection.

That comes from STEDI-STATE Power Conditioning. If you're a Florida Power customer, our Energy Experts will keep you up and running with a free service call. That means visiting your location, identifying problems and finding the answers.

If appropriate, they'll also install monitoring equipment. Recommend the products you need, from voltage regulators to backup battery systems. Even arrange for delivery and skilled installation.

And the Energy Experts will *stay* on your team, ready to assist when you need greater capacity or future modifications. Call Bob Phillips, Power Conditioning Program Coordinator, 1-800-445-3320 toll-free for information on STEDI-STATE Power Conditioning.

We'll prove that bad weather can't keep a good machine down.

Florida Power
CORPORATION

Call the Energy Experts at 1-800-445-3320.

For Your Benefit...

From The Florida Medical Association Sponsored Insurance Plans.

Diagnosis: FMA Members and Employees, Need Dependable, Comprehensive Coverage In Medical Care, Life, Disability and Dental At Economical Group Rates

Treatment: Enroll NOW in Your Florida Medical Association Sponsored Insurance Plans

Prognosis: Excellent. FMA-SIP Offers Flexibility, Convenience, Efficiency In An Insurance Package Designed Exclusively For You.

• Major Medical • Dental • Short-Term Disability • Life And AD&D

☐ Developed from your specifications by your Association and offered exclusively to FMA members and their employees. Dependents coverage available for Medical and Dental benefits.

☐ Marketing by Florida's leading insurance consultant, Brown and Brown, Inc., for further information contact us at the toll free number below.

☐ Underwritten by one of America's largest and strongest insurance companies, Mutual of Omaha.

☐ Administered by FLAMEDCO, Inc., highly regarded for rapid, efficient claims and enrollment administration and a wholly owned subsidiary of your own Florida Medical Association.

FMA/SIP Offers You Great Flexibility. You Choose The Coverage You Need:

Major Medical, Million-dollar protection with your choice of $200 or $500 annual deductibles and the new Medical Deluxe Plan.

Dental, Benefits of up to $1,000 per person each year. Optional if you elect Major Medical.

Life, Group term life insurance coverage for you and your employees. You select coverage level from $10,000 to $100,000.

Disability, If you elect life insurance, you also may choose from among four short-term disability options, either 13-week or 26-week coverage with or without maternity.

Call Toll-Free
1-800-624-3953 *For Details*

P.O. Box 4938
Jacksonville, Florida 32201



Florida Medical Association, Inc.
Sponsored Insurance Programs

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
SEPTEMBER 1986, Vol. 73, No. 9

Advances in medical fraud: chelation therapy replaces Laetrile

Mark R. Montgomery, Ph.D.

ABSTRACT: Historically, medical quackery has enjoyed a somewhat colorful image, examples of which range from the frenzied dances of the tribal "witch doctor" to hair tonic salesmen operating out of covered wagons. More recently, licensed medical practitioners and their imitators have added personal sophistication, professional legitimacy, modern technology, and mass communication to this profitable practice. The most famous medical fraud, Laetrile, produced a billion dollar industry before its demise. Currently, a legitimate medical treatment, chelation therapy, is being distorted and marketed to an unsuspecting public. Like Laetrile, illegitmate chelation therapy has utilized the traditional patterns of development and salesmanship that have become hallmarks of medical quackery. Unlike Laetrile that denied proper treatment to the seriously ill, economic injury is the most common residual damage suffered by the majority of chelation therapists' patients. However, the medical community should be aware of the characteristics of illegitimate chelation therapy and the potential dangers to which the victims are subject. Numerous real disorders may go untreated and, as importantly, the bogus treatments place the subjects at very real medical risk.

The Author
MARK R. MONTGOMERY, Ph.D.
Dr. Montgomery is Professor of Toxicology at the University of South Florida College of Public Health and Director, Toxicology Laboratories, Research Service, Veterans Administration Hospital, Tampa.

As a multibillion dollar industry, Laetrile was the most successful medical fraud in history. The next generation of medical sleight-of-hand has produced "Chelation Therapy" which promises to be as successful, if not more so, than Laetrile. All the classical hallmarks of quackery are retained with two important additions. Unlike Laetrile, which promised to cure only one disease, this treatment is purported to cure many diverse, common ailments. To confuse the issue further, chelation therapy has a legitimate place in medical practice that the illegitimate practice distorts. A brief review of the characteristics of quackery and the rise and fall of Laetrile will provide the background for understanding illegitimate "Chelation Therapy."

History and characteristics of quackery • Long before establishment of conventional medicine, individuals roamed the countryside providing various cures for ailments common to the time. Other than intent, there is little difference between these early quacks and those who practiced early herbal medicine. A gentle apology is available for these "medicine men" for their honest, if erroneous, beliefs. In fact, a few of the herbal remedies, e.g., foxglove, quinine, cocaine, atropine, remain valuable in modern medicine. However, as medical science progressed in sophistication, so followed the charlatan in perversion of fact for profit. While humor may be a common response to the colorful "snake oil" salesman of western melodrama, response to the modern counterpart is more serious and, certainly, more expensive.

Two stereotypes of the modern quack have developed. The first — the conscious quack — is usually articulate and prosperous and, not uncommonly, may be credentialed in legitimate medicine

in an area related to his quackery. Entrepreneurs for whom there is no established specialty to pervert will often create ("found") the area themselves complete with "professional" society (founding officer) and journal (editor). The second stereotype — the unconscious quack — is usually weakly educated or may be long removed from contemporary standards, practices, and advances. For these individuals, understanding modern medicine is difficult or impossible and may even be intimidating. They seek simple, understandable answers to complicated problems while ignoring H.L. Mencken's prophetic advice, "For every complex problem there is a simple solution — and it is wrong." This individual will appear as a well-meaning soul when brought to accountability before the legitimate medical community or legal system.

Medical fraud has several recurring characteristics that are independent of the intent of the perpetrator and may be considered as classical hallmarks, the most common and least understood of which is abuse of the scientific method.[1] When investigating a problem, a scientist will record related observations and, from those observations, formulate a causal hypothesis. The quack reverses the process by deciding what he wishes to prove and then records or creates supporting observations. Any negative data are ignored. The scientist examines the validity of the hypothesis with appropriate experimentation and reports all data to his peers for evaluation, replication, confirmation, or refutation. The fraud takes his collection of evidence in the form of testimonials and selected observations directly to the lay public. He will avoid professional journals that require critical review in favor of the mass media, e.g., "talk shows," tabloids, womens' magazines, mens' light pornographic magazines, etc. Unlike peer communication that stimulates discussion over positive and negative evidence, the public forum is used to challenge all critics to disprove the hypothesis. This is a clever and facile reversal of the scientific practice of presenting evidence in proof; the fraud presents no controlled data in substantiation but rather challenges science to disprove the unsubstantiated hypothesis. Anyone questioning the theory is accused of prejudice or conspiracy with a jealous medical "establishment." This contrast between science and quackery may be summarized in Table 1.

Table 1. — Comparison of Science and Quackery.

Science	Quackery
Observe	Hypothesize
↓	↓
Hypothesize	Select Observation
↓	↓
Experiment	Communicate (Public)
↓	↓
Communicate (Peers)	Challenge to Disprove
↓	↓
Accept or Reject Hypothesis	Attack Negative Opinions

The challenge to disprove (step 4), rather than provide objective evidence in support of the theory, is one example of the typical distortion of scientific logic. Additional examples of this effective use of non-sequitur are:[2]

> If criticized for giving an excessive dose of his "medication," the quack will correctly reply that large doses of anything are harmful and incorrectly assert that his drug is, therefore, as good as anything else.
>
> If criticized for apparent toxicities of his "medication," the quack will correctly reply that other drugs can have toxic side effects and incorrectly conclude that his drug is, therefore, justifiable.
>
> If criticized that the treatment cannot possibly succeed based on known scientific principles, the quack will reply, "How can you say my remedy does not work if you do not use it?"

Why Laetrile finally failed • In the history of medical fraud, no single incident has been as successful as the noncure for cancer, Laetrile. The history, development, exploitation, and danger of this relatively simple chemical (amygdalin) are well documented.[2-5] The extraordinary financial success of Laetrile is measured in billions of dollars. The political success is astounding in that numerous states legalized prescription of this toxic, useless chemical. If it was so widely accepted by the lay public, why did it finally fail? The reason is twofold: Laetrile was the victim of fact and its own fiction.

Because the purported mechanism for Laetrile's therapeutic action was easily discountable on several biochemical bases, the legitimate medical and scientific community was reluctant to spend the time and resources necessary to disprove the claims. When the appropriate clinical trials finally were completed, the expected was confirmed: "Amygdalin (Laetrile) is a toxic drug that is not effective as a cancer treatment."[4] The fact was public.

The fiction of Laetrile was slower to be acknowledged publicly. Laetrile finally succumbed to its own "Concept of Shifting Claims," another characteristic maneuver of quackery not unlike the shell and pea game. In this scheme, original claims are kept simple. As failure becomes evident, claims are "shifted" to higher degrees of complexity. Each consecutive elevation of claims produces its own series of treatments, promises, and finally, excuses. The sequence for Laetrile can be summarized: first, a drug that cures cancer; then, a cancer preventer; then, a drug to "make patients feel better;" then, must be used with "organic" dietary programs; then, must be used with complete program of "holistic" medicine; finally,

bizarre variations such as the requirement to be taken simultaneously with "enzyme enemas" ("colonic therapy").

The combination of fact and fiction convinced the public and its legislators. With the passing of Laetrile, an opportunity was created for the next generation of scientific chicanery that has been filled successfully by "Chelation Therapy." All the classical hallmarks of quackery have been retained with the addition of increased sophistication. The novel twist in this new fraud is the extrapolation of a legitimate therapeutic modality to treatment of numerous common ailments and general complaints. To understand the inappropriateness of this extrapolation, review of the proper, limited use of chelation therapy may be helpful.

Chelation therapy in legitimate medicine • This therapy, whose name is derived from the Greek root *chela*, for claw, is an effective treatment for documented heavy metal intoxication. The mechanisms of therapeutic action are simple and twofold. First, heavy metals are most toxic when free in body fluids ("biological availability"). The chelating agent binds to the target molecule and forms a biologically inactive complex, a "chelation complex." The second therapeutic mechanism, increased renal excretion, occurs simply because the chelation complex is more water soluble than the free metal. The more hydrophilic a given substance, the greater its renal tubular retention and, hence, the more rapidly it will be excreted. These two mechanisms work in combination to decrease the blood level of the biologically available metal.

Four chemicals comprise the basic clinical armamentarium of effective chelating agents. The selection of a specific agent for a particular metal is based on the affinity coefficient; the higher the affinity for a metal, the more efficient the binding. The principal metals encountered clinically and the chelating agents normally employed are in Table 2.

The last example, cadmium, is especially important. The principal toxicity from cadmium is renal damage, which in severe cases may progress to total kidney failure. As mentioned earlier, one result of chelation therapy is increased urinary excretion of the target metal. This urinary effect also results in a transient rise in the renal concentration of metals. In the case of cadmium, that increased concentration results in increased toxicity.

Table 2. — Encountered Metals and Normally Chelating Agents.

Metal	Chelating Agent
Lead	EDTA (ethylenediaminetetraacetic acid) and dimercaprol (British Anti-Lewisite, BAL)
Mercury	Dimercaprol and penicillamine derivatives
Arsenic	Dimercaprol
Iron	Deferoxamine (also spelled desferrioxamine)
Copper	Penicillamine derivatives
Zinc	Penicillamine derivatives
Cadmium	Chelation therapy contraindicated

Each of these chelating agents has toxicity of its own. Because of this limitation, chelation therapy is appropriate only in cases of documented metal intoxication. In cases of mild intoxication, where documentation is weak or where symptoms are nonthreatening, careful monitoring of the patient is appropriate to determine whether initiation of chelation therapy is warranted. If the exposure situation to the metal can be established, the best "therapy" may be to alter the patient's environment to prevent further exposure. Chelation therapy is not used indiscriminately.

Chelation therapy as quackery • The unsubstantiated premise for the inappropriate application of chelation therapy is that numerous complaints and diseases are due to low body burdens of metals. Routinely included in this catch-all are hypertension, arteriosclerosis, and arthritis. Metals are also the purported cause of complaints that may have psychological basis, e.g., restlessness, insomnia, headaches, anxiety, etc. When a potential client presents a complaint, the chelation therapist will "document" metal intoxication. Since this diagnosis cannot be supported by legitimate means (blood and urine analysis), the therapist will use hair analysis. The rationale presented is that hair reflects the body burden of metals while in truth hair reflects only the total exposure of an individual's head to the environment. Hair may absorb metals from the air, from washing in metal-containing water, or even from shampoos, e.g., one national brand shampoo has a high zinc content, ostensibly for dandruff control. In none of these situations is ingestion necessarily concurrent. No attempt is made to correlate data from hair analysis with body fluids or with known signs and symptoms of specific metal toxicity; there is, in fact, no correlation. An exemplary situation:[6] two women washed their hair daily in water that had a high copper content. The concentration of copper in their hair became so elevated that the hair turned green, characteristic of very high copper concentration. A similar copper concentration in the blood would have produced severe gastrointestinal symptoms. No copper toxicity was evident in these women.

The practitioner will defend himself by charging that "establishment science" uses hair analysis routinely while conveniently omitting any mention of how or why the "establishment" uses this analysis. Hair analysis can be used legitimately to examine total exposures of large populations over long periods of time. For example, an appropriate use of hair analysis might be to provide evidence for a theoretical hypothesis that people in New York have more total

exposure to metals than a similar population in Los Angeles. A large study population would be selected as nearly equal as possible in all parameters except residence and would be required to live in the appropriate city with minimal outside travel. Hair samples would be taken initially to provide a baseline. Then, and only then, would the data have any validity when the populations were re-examined in several years.

When hair analysis has been completed, the patient may be shown the "data" that will document the presence of heavy metals. The therapist will not tell the patient that all hair contains detectable concentrations of heavy metals. If the laboratory providing the analysis happens to provide normal ranges and if the patient does not exceed these, the therapist is not defeated. In his experience his patient's level is still "too high" and is "toxic." Treatment is recommended.

Originally, treatment was restricted to administration of low doses of a chelating agent only, usually EDTA. As the failure of this treatment became apparent, chelation therapy utilized the "Concept of Shifting Claims." Since the purported problem with the previous treatment was "nutritional imbalance," regimens were altered to include "nutritional supplementation," usually standard vitamin preparations with salts and glucose. Recently a new component has been added, DMSO (dimethylsulfoxide). The premise for DMSO is that this chemical alters cell membrane permeability (a true statement), therefore DMSO will facilitate cellular penetration of EDTA (a false conclusion). For the latter to have a chance of being true, the volume of IV DMSO would be so large that vascular damage and erythrocyte destruction would be extensive. Additionally, the chelation therapist fails to acknowledge, or simply does not know, that the molecular structure of EDTA precludes its entry into cells.

Finally, monitoring therapeutic success is purely symptomatic, i.e., the patient is encouraged to "feel better." If the patient does not report improvement, more treatments are offered with an altered protocol.

Dangers of illegitimate chelation therapy ● The most significant danger, one common to all medical fraud, is lack of proper diagnosis and treatment. Chelation therapy presents a common diagnosis for all complaints and provides a common ineffective therapy. Little distinction is made between trivial and serious diseases and legitimate treatment is provided for neither. In the event of true heavy metal intoxication, the patient is at serious risk. Initial evaluation will not establish the body burden of the specific metal. EDTA is the chelating agent given routinely; however, EDTA is appropriate for only a few metals. Therefore, the appropriate chelating agent may not be used. Since improper initial evaluation is made, final evaluation of therapeutic success or failure is impossible. If the patient happens to have cadmium intoxication, the danger of this fraudulent therapy is life-threatening. This fact is unknown or disregarded by the therapist as evidenced by the inclusion of "cadmium intoxication" as one of the many conditions claimed to be curable by his practice. Fortunately, true cadmium intoxication is rare.

Numerous subtle dangers are presented also by the supplements included in the chelation solution. The vitamins are generally innocuous; the salts and glucose are not. A typical salt supplement is potassium chloride. The cardiac sensitivity to $[K^+]$ dictates careful monitoring in the clinical setting, a small imbalance having potentially serious consequences. Indiscriminate administration of glucose is also not without risks, for example to the undiagnosed diabetic. Inclusion of nonprescription grade chemicals in these supplements also presents significant risks. As described earlier, DMSO may cause vascular damage and erythrocyte destruction. Additionally, chemicals not prepared specifically for intravenous human usage may not be sterile and frequently harbor pyrogens.

The most obvious damage is economic. A standard solution of EDTA, vitamins, salts and glucose will cost $20-$30; a standard treatment regimen will require 25-30 such installments. This price does not include initial evaluation, diagnosis, laboratory tests (hair analysis), consultation, final evaluation, and follow-up visits. Total charges in excess of $1,000 are not uncommon, a burden that must be borne entirely by the individual since medical insurance and health care plans do not recognize this application of chelation therapy as legitimate medical practice.

Recognizing the illegitimate practice ● This discussion could be titled: "Differentiating Chelation Therapy From Chelation Therapy." Therein lies the problem — the illegitimate practice utilizes the language of legitimacy while maintaining all the classical hallmarks of quackery that are time-tried and proven successful. The differences between proper and improper chelation therapy may be obvious to qualified medical personnel, but to the lay public the differences are so subtle as to be unrecognizable. The practitioner relies heavily upon this subtlety.

If the lay public is to be expected to make a rational choice, information must be provided. This involves public education to a very basic scientific literacy and an appreciation of simple logic. History demonstrates that this is not accomplished easily. Another approach is aggressive pressure from professional regulatory organizations. This is proceeding in many states but is a laborious procedure that recognizes only individual cases. Finally civil litigation, if pursued in a timely manner, could make the cost of participating in this fraudulent practice unacceptable. Quackery bows more slowly to science than to economics.

Conclusions ● 1. Fraudulent chelation therapy is quackery in the classical tradition of Laetrile.

2. In legitimate medical practice, chelation therapy has specific usage in cases of documented heavy metal intoxication.

3. In illegitimate chelation therapy, treatment is extrapolated to a variety of complaints and diseases.

4. Illegitimate chelation therapy frequently uses hair analysis to "document" metal intoxication. Hair analysis is not a valid clinical test.

5. Illegitimate chelation therapy is not only a financial fraud of large magnitude but also places the victim at significant medical risk.

References

1. Arseneau, J.C. and Thigpen, J.T.: The New Quack — Pseudoscience, Public Relations and Politics, J. Miss. State M. A. 22:202-207, 1981.
2. Herbert, V.: Laetrile: Cult of Cyanide. Promoting Poison for Profit, Am. J. Clin. Nutrition 32:1121-1158, 1979.
3. Lerner, I.J.: Laetrile: Lesson in Cancer Quackery, CA — A Cancer J. for Clin. 31:91-95, 1981.
4. Moertel, C.G.; Fleming, T.R.; Rubin, J., et al: Clinical Trial of Amygdalin (Laetrile) in Treatment of Human Cancer, N. England J. Med. 306:201-206, 1982.
5. Smith, F.P.; Butler, T.P.; Cohan, S., et al: Laetrile Toxicity: Report of Two Cases, JAMA 238:1361, 1977.
6. Nordlund, J.J.; Hartley, C., and Fister, J.: On the Cause of Green Hair, Arch. Dermatol. 113:1700, 1977.

● Dr. Montgomery, Professor of Toxicology, University of South Florida College of Public Health, Tampa 33612.

Clinical and radiological aspects of the superior mesenteric artery syndrome

Ricardo Bedoya, M.D., Sergio M. Lagman, M.D., George P. Pennington, M.D., and Amnath Kirdnual, M.D.

Superior mesenteric artery syndrome (SMAS) is an unusual form of high intestinal obstruction. Controversy exists about the cause and treatment. Most clinicians agree that the syndrome exists and that its cause is obstruction of the duodenum from pressure of the superior mesenteric artery and that certain extrinsic factors may precipitate what is usually intermittent occlusion of the duodenum at this point. We present a case of SMAS, demonstrating its clinical and anatomical features. A partial review of the literature is summarized.

Case report • A 22-year-old white female was admitted on 9/16/85. She had a two-week history of nausea and vomiting after meals, intermittent, vague, abdominal pain, constipation, and weight loss.

Her past history revealed that she had an appendectomy in 1975. She is married, gravida 0 and is on birth control pills. She denied any significant family problems. She did not smoke and drinks socially only occasionally.

Physical examination revealed a slender, dehydrated female, height 5'4", weight 115 pounds. Vital signs were normal. Her abdomen was soft with mild tenderness to pressure on the epigastrium and the suprapubic area. Hyperactive bowel sounds were noted. Pelvic and rectal examinations were negative and the remainder of the examination was unremarkable. All laboratory test results were negative except for mild elevation of total and direct bilirubins. These were thought to be secondary to birth control pills and discontinuation caused a decrease to normal levels.

An upper GI series performed on 9/27/85 during an acute episode of upper abdominal pain and persistent nausea and vomiting revealed appreciable dilatation of the stomach and proximal portions of the duodenal loop with abrupt cutoff at the distal portion of the transverse segment of the duodenum (Fig. 1). The dilatation of the duodenum was noted proximal to the usual point at which the superior mesenteric artery crosses anterior to it. The fluoroscopic part of the examination revealed vigorous as well as reverse, peristaltic activity. There was prolongation of the emptying time of the stomach and duodenum. Hypotonic duodeno-

The Authors
RICARDO BEDOYA, M.D.
SERGIO M. LAGMAN, M.D.
GEORGE P. PENNINGTON, M.D.
AMNATH KIRDNUAL, M.D.
Dr. Bedoya is Chairman of the Department of Radiology, Dr. Lagman is a staff radiologist in the Department of Radiology, Dr. Pennington is a general surgeon and chief of medical staff, and Dr. Kirdnual is an obstetrician-gynecologist at Lake Shore Hospital, Lake City.

graphy was positive for marked dilatation of the proximal portion of the duodenum, prominent duodenal folds, and persistent compression of the distal portion of the duodenal loop (Fig. 2). Follow-up upper GI series while the patient was relatively free of symptoms revealed appreciable decompression of the duodenal loop with only a slight prominence of the mucosal folds (Fig. 2B). Smooth extrinsic impression upon the third duodenal portion was, however, again observed. The patient was discharged and treated conservatively. Approximately three weeks later she was readmitted to the hospital with complaints of nausea and vomiting after meals and weight loss of approximately 19 pounds since her last admission. Simultaneous selective mesenteric arteriogram and hypotonic duodenography were performed with demonstration of appreciable dilatation of the proximal portions of the duodenum and marked extrinsic impression involving the transverse portion of this organ in the area corresponding to the point of contact with the superior mesenteric artery (Fig. 3). This pressure defect was persistent after the injection of contrast material (Fig. 4). At surgery the stomach and the proximal portions of the duodenum were distended. The distal portion of the transverse duodenum was compressed by the superior mesenteric artery.

The jejunum was much smaller.

Side-to-side retrocolic duodenojejunostomy was performed.

During the first postoperative week, the patient continued to complain of nausea and vomiting. She gradually improved and was discharged eating normally and regained two pounds weighing 98 pounds.

In follow-up office visits, the patient showed some improvement in her general condition. She weighed 110 pounds at last report. At times she presented with different complaints but has remained free of symptoms of upper gastrointestinal obstruction.



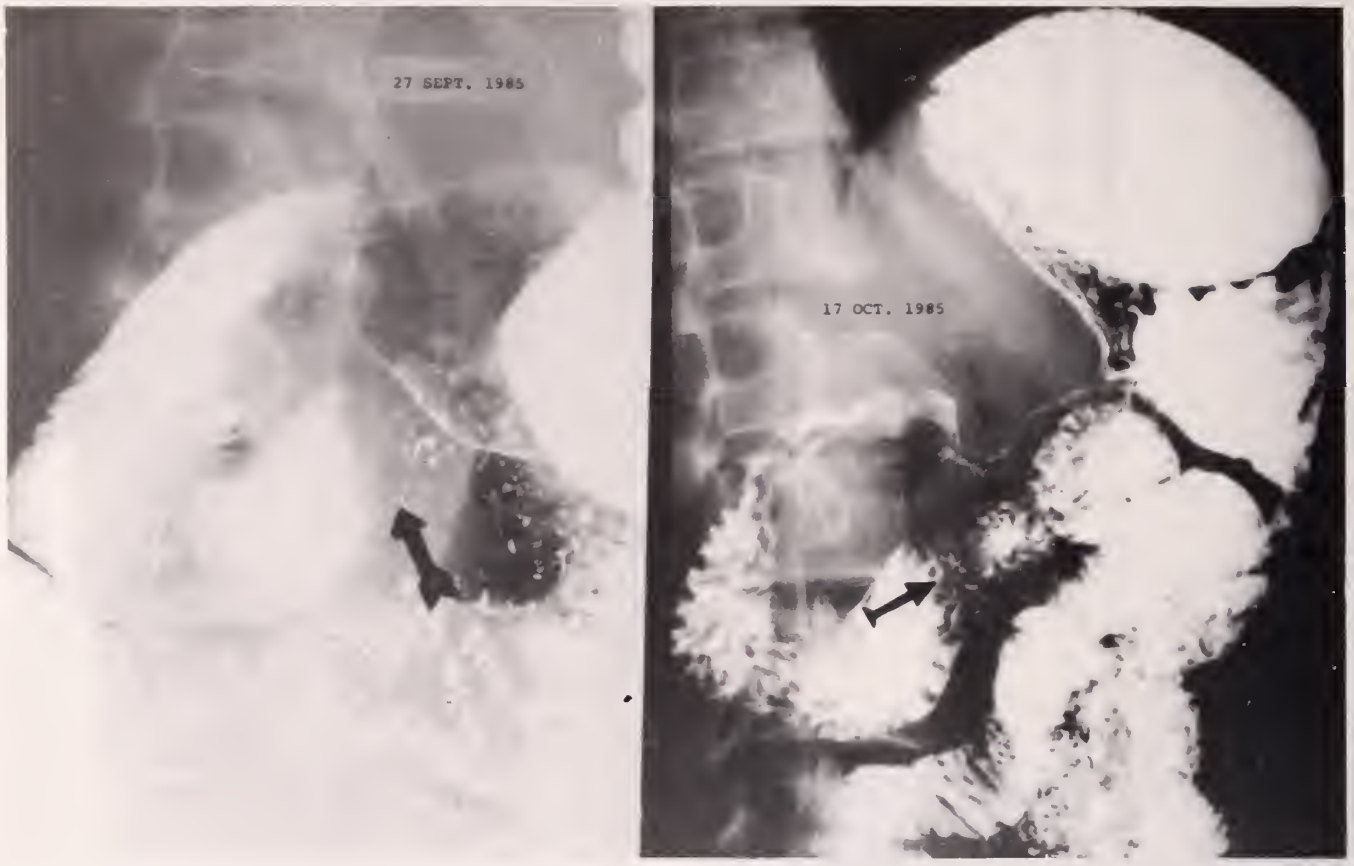
Fig. 1. — Supine film from initial upper GI series performed during an episode of acute exacerbation demonstrating dilatation of the stomach (arrowhead) and proximal portions of the duodenum (small arrow) with termination of barium column (large arrow) in the third portion of the duodenum. Fluoroscopy revealed intermittent reversed duodenal peristaltic activity.

Discussion • According to Gray and Skandalakis, the first description of this condition appears to be that of Boener in 1854, but Rokitnasky in 1884 was the first to suggest its etiology. Bloodgood in 1907 suggested duodenojejunostomy for its treatment and Stavely has been credited with performing the first duodenojejunostomy for the condition in 1908. In 1921 Wilkie made the most thorough study published up to that time; hence the eponym Wilkie's syndrome.

Duodenal dilatation (megaduodenum) may be observed in a large number of clinical conditions including diabetes mellitus, systemic lupus erythematosus, scleroderma, myxedema, amyloidosis, myotonic dystrophy, and chronic idiopathic intestinal obstruction. In the multiple series of cases reported by different authors severe catabolism and loss of fat, for example, after operation, prolonged illness or prolonged bedrest, burns, and trauma, have been considered contributing factors.[1-4] Willett in 1878 reported a case of mesenteric vascular compression associated with the application of plaster casts for the treatment of spinal deformities.[5] The term, "cast syndrome," originally introduced by Dorah in 1950 is thought to be due to extension of the spine, accentuating the pressure from the SMA. The symptoms have been observed after traction exerted by the Milwaukee brace, Harrington distraction rod, halofemoral apparatus, and Risser localizer cast which probably precipitates vascular compression of the duodenum by the same mechanism.

A number of congenital factors that predispose the patient to duodenal compression have been suggested. These include congenital pronounced lordosis, short ligament of Treitz, aberrant mesenteric artery or anomalous branches of this vessel, excessive mobility of the right colon, malrotation of the intestines, and abnormally high fixation of the suspensory muscle of the duodenum.[1,6-8] No patients with vascular compression of the duodenum have been described as obese.

The posterior limb of the angle is formed by the vertebra and the aorta, and the anterior limb is formed by the superior mesenteric artery. Any factor that reduces or closes this angle can cause narrowing of the transverse duodenum causing the clinical picture of SMAS.[6,9] Even in normal persons, there is often delay of barium passage through this area.[9] Roentgenographic measurements of the angle in normal patients have been reported to be 25-60°. The same aortic-mesenteric angle has been found to be as little as 10-20° in numerous reported cases of SMAS.[10,11]



Figs. 2, 2A. — Oblique fluoroscopic spot film of hypotonic duodenography shows dilatation of proximal portions of the duodenum and thickening of duodenal mucosal folds. There is also noted a persistent extrinsic pressure defect involving the distal portion of the transverse duodenum (large arrow); 2B. — Oblique projection of upper GI series performed during symptom-free period reveals significant decompression of the duodenum. There is a smooth, bandlike, extrinsic impression in the distal portion of the transverse duodenum with preservation of normal duodenal mucosal pattern (arrow).

SMAS is a rare condition occurring at an incidence of 0.013% at the Lahey Clinic.[4] The syndrome can be acute and lead to death but is usually chronic and intermittent with nonspecific symptoms such as epigastric pain, occasional vomiting and postprandial discomfort. The symptoms are suggestive of other gastrointestinal disorders. It is, therefore, clinically difficult to differentiate between peptic ulcer disease, cholelithiasis, chronic pancreatitis and abdominal angina. Moreover, there has been reported coexistence of SMAS, peptic ulcer disease, and bile reflux gastritis.[1,4,10-14] The lack of specific symptoms in some cases explains why many patients have been treated for years with varying diagnoses including "stomach trouble," "chronic appendicitis," "peptic ulcer," "dyspepsia," and "nervous stomach." Many have had exploratory laporatomies without positive findings.[4,11] Either as a matter of pure coincidence or as a part of the series of clinical circumstances frequently related to this syndrome, it is interesting to observe that our patient's clinical history was positive for appendectomy in 1975.

Because of this, the radiological work-up plays the most important role in establishing the diagnosis. Plain roentgenograms of the abdomen during the attack may demonstrate gastric and duodenal dilatation with little gas in the remainder of the bowel. The upper GI series during an acute exacerbation may be expected to show gastric and duodenal dilatation as well as the characteristic vertical linear extrinsic pressure defect in the third portion of the duodenum (Fig. 1, 2A). Intermittent reversal of the peristaltic activity in the duodneum, as observed in our case, is a frequently noted fluoroscopic finding. This phenomenon has been said to be indicative of duodenal obstruction.[1,4,5,11,15] During fluoroscopy, temporary relief of the obstruction can be demonstrated in some cases by turning the patient into the prone, left decubitus and/or knee-chest positions.[9] The roentgenographic features may be either less obvious or absent in a symptom-free period (Fig. 2B). Diagnostic accuracy can be augmented by performing hypotonic duodenography.[6,12] This procedure can be especially helpful in diagnosing megaduodenum. It is a reliable, easily performed study. In doubtful situations, a superior mesenteric arteriogram plus hypotonic duodenography can establish the diagnosis.[12]



Fig. 3. — Subtraction film of simultaneous hypotonic duodenography and selective mesenteric arteriography. Notice gastroduodenal tube (arrowhead) and observe marked dilatation of proximal duodenum with associated thickening of duodenal mucosal folds (small arrow). The superior mesenteric artery is producing marked vertical extrinsic impression in the distal part of the transverse duodenum (large arrow).



Fig. 4. — Delayed film of the same simultaneous selective superior mesenteric arteriogram and hypotonic duodenography indicating persistence of the superior mesenteric artery extrinsic pressure defect in the distal portion of the transverse duodenum (large arrow) with secondary dilatation of the proximal portions of the duodenal loop and thickening of the duodenal mucosal folds (small arrow).

A conservative approach to management such as dietary regulation with frequent small meals is ordinarily advisable as obstruction is seldom complete and a number of patients may spontaneously recover. When conservative measures fail, bypass procedures such as duodenojejunostomy and gastrojejunostomy as well as lysis of the ligament of Treitz have been reported.[11] Duodenojejunostomy is usually considered the surgical treatment of choice.[5,11,13] The operative procedure involves an anastomosis of dilated atonic bowel; hence the anastomosis may not function until the duodenum regains normal size and tone, which frequently takes several weeks.

Conclusion • Superior mesenteric artery syndrome is a rare condition caused by the compression of the third part of the duodenum by the superior mesenteric artery. Much of the controversy about the syndrome concerns its confusion with other causes of megaduodenum. Multiple clinical conditions associated with significant and rapid weight loss have frequently been reported as precipitating factors. The presence of SMAS can be suspected clinically but making the final, nonsurgical diagnosis is a radiological problem. Therefore, careful evaluation of the clinical as well as the radiographic features must be made when confirming the diagnosis. In many cases, conservative medical management such as frequent small meals may provide relief of the obstruction and associated symptoms but, in some instances, surgical intervention is necessary.

References

1. Cohen, L.B.; Field, S.P., and Sachar, D.B.: Superior Mesenteric Artery Syndrome, The Disease That Isn't, or Is It? J. Clin Gastroenterol. 7(2): 113-116, 1985.
2. Lee, Chung-Seng and Mangla, J.C.: Superior Mesenteric Artery Compression Syndrome, Am. J. Gastroenterol. 70:141-150, 1978.
3. Hines, J.R.; Gore, R.M., and Ballantyne, G.H.: Superior Mesenteric Artery Syndrome, Am. J. Surg. 148:630-632, 1984
4. Wang, Yung-Huei and Takada, T.: Superior Mesenteric Artery Syndrome, Report of Four Cases, Gastroenterol. J. 19:479-485, 1984
5. Sapkas, G. and O'Brien, J.P.: Vascular Compression of Duodenum (Cast Syndrome) Associated with the Treatment of Spinal Deformities, Arch. Orthop. Traumat. Surg. 98:7-11, 1981.
6. Hernandez, E.; Martinez, A., and Gonzalez, J.: Compression Vascular del Duodeno, Rev. Esp. Enf. Ap. Digest 65:41-48, 1984.
7. Shackelford, R.T. and Zuidema, G.: Obstructive Disorders in Surgery of Alimentary Tract, 2nd. ed., Chap. 5, Vol. II, Philadelphia, W.B. Saunders Company, 1981.
8. Wayne, E.R.; Miller, R.E., and Eiseman, B.: Duodenal Obstruction by Superior Mesenteric Artery in Bedridden Combat Casualties, Ann. Surg. 174:339, 1971.
9. Eisenberg, R.L.: Diagnostic Imaging in Internal Medicine, New York, McGraw-Hill Company, 692-695.
10. Walsh, T.N.; McPhillips, M., and O'Higgins, N.: Extrinsic Compression of Duodenum-Wilkies Syndrome, Ir. J. Med. Sci. 152(3): 129-133, 1983.
11. Gustafsson, L., et al: Diagnosis and Treatment of Superior Mesenteric Artery Syndrome, Br. J. Surg. 71:499-501, 1984
12. Lukes, P.J., et al: Diagnostic Value of Hypotonic Duodenography in Superior Mesenteric Artery Syndrome, Acta Chir. Scand. 144:39-43, 1978.
13. Corfield, A.P. and May, R.E.: Vascular Compression of Duodenum — Operative and Non-Operative Treatment, Bristol Med. Chir. J. 99:111-112, 1984
14. Thompson, N.W. and Stanley, J.C.: Vascular Compression of Duodenum and Peptic Ulcer Disease, Arch. Surg. 108.674, 1974.
15. Teplick, J. G. and Haskin, M.E.: Surgical Radiology, Vol. 1, 1981, Philadelphia, W.B. Saunders Company, 524-526.

Acknowledgment

We express our appreciation to Henry E. Plenge, M.D., for review of the manuscript. We are also grateful for the cooperation received from the x-ray technologists of the Department of Radiology of Lake Shore Hospital. Special thanks is extended to Melba L. Reynolds for her secretarial assistance.

• Dr. Bedoya, Department of Radiological Services, P.O. Box 1989, Lake City 32056-1989.

Seizures and action myoclonus after occupational exposure to methyl bromide

Leon D. Prockop, M.D., and Allen O. Smith, M.D.

ABSTRACT: Methyl bromide is used as a fumigant, refrigerant and in various chemical processes. A 46-year-old man suffered status epilepticus from which he recovered and action myoclonus which has persisted for five years after chronic and acute exposure to methyl bromide while fumigating houses occupationally.

Methyl bromide, a colorless and almost odorless gas at room temperature, is used as a refrigerant, fire extinguisher, and insecticide. Occupational exposure has resulted in damage to the kidneys, lungs and nervous system. Nervous system manifestations include drowsiness, psychosis, seizures, dysarthria, ataxia, intention myoclonus and peripheral neuropathy; the last at chronic low doses, the others after acute high dose exposure. An interval between exposure and onset of serious symptoms is common.[1]

We report a man who suffered status epilepticus which resolved and action (intention) myoclonus which has persisted for five years after accidental exposure to methyl bromide in the context of occupational house fumigation.

Case report • A healthy 46-year-old man used methyl bromide daily for many years as a house fumigator, generally in a house "tenting" procedure. Apparently a protective face mask, always used, was ineffective for a short time on 10/14/80. Thereafter he suffered malaise and weight loss, continuing to work. Further accidental exposure occurred on 10/24/80. Tremor and increased malaise prompted a hospital emergency room visit where a heart rate of 128 beats/minute and a blood pressure of 170/110 mm Hg were recorded. Tremor, malaise and anorexia persisted until 11/3/80 when status epilepticus ensued requiring hospitalization. General medical examination, except for a heart rate of 110/minute, was normal. Neurologically, he was comatose without focal deficits exhibiting repetitive generalized major motor convulsions, frequently precipitated by sensory stimuli. Between convulsions, myoclonic limb movements occurred.

A complete blood count showed a white count of 14,100 with a left shift. This subsequently became normal. Normal studies included routine urinalysis, urine salicylate level, pseudocholinesterase, uric acid, calcium, phosphate, BUN, LDH, sodium, chloride, CO_2, potassium, arterial pO_2, sugar and cerebrospinal fluid analysis including pressure, cells, sugar, protein and protein electrophoresis. Serum bromide level was 35 mg/dl on admission, falling to 3 mg/dl 29 days

The Authors
LEON D. PROCKOP, M.D.
ALLEN O. SMITH, M.D.
Dr. Prockop is Professor and Chairman, Department of Neurology, University of South Florida College of Medicine, Tampa, and Dr. Smith is Clinical Assistant Professor of Neurology, University of South Florida College of Medicine, as well as a practicing neurologist in St. Petersburg.

later. A brain CT scan was normal. An electroencephalogram was interpreted to be severely abnomral, containing multiple high voltage paroxsymal spiked wave forms, highest in amplitude over the right hemisphere.

Status epilepticus resolved after intravenous therapy with sodium phenobarbital and lorazepam. No further seizures occurred with chronic phenytoin therapy. He gradually regained consciousness, being fully alert on 11/18/80. At rest he was normal neurologically. Coarse jerking movements, best characterized as myoclonic movements, occurred on any attempt to grasp or use objects, e.g., feeding efforts. These were more prominent on the left than the right. Gait ataxia was evident with occasional whole body myoclonic movements causing falls.

During subsequent five years of follow-up the EEG has returned toward normal, exhibiting occasional mild dysrhythmia. Only one generalized seizure has occurred, this in the context of hospitalization for placement of a cerebellar pacemaker at which time chronic clonazepam therapy was temporarily discontinued. Treatment of the action myoclonus including diazepan and clonazepam as well as cerebellar pacemaker has yielded only mild amelioration. A variety of other medicinal therapeutic trials was without benefit.

Examination of 5/20/83 demonstrated a normal general physical examination with neurological examination, including mental status, normal except for dysarthria; coarse, jerking arm movements at attempts to perform skilled and purposeful actions; leg dysmetria with occasional coarse movements on intention; and a broad based gait with occasional myoclonic body movements. Activities of daily living such as buttoning of clothing and eating cannot be performed.

Discussion • Methyl bromide shares toxicity with related monohalogenated methanes, i.e., methyl chloride and methyl iodide. The density of 3.3 times that of air and noninflammability have led to its use as a fire extinguisher. Its high lipid solubility, penetrating power, and rapid toxicity make it valuable as an insecticide, characteristics which also cause danger to mammals.[1,2]

Human toxicity was first reported in 1898 by Schuler.[3] In 1946 Van Oettingen reviewed 308 reported cases, 28 ending fatally.[4] Moses and Klawans have provided a thorough review.[1]

Methyl bromide affects the respiratory tract, gastrointestinal tract, skin, heart, kidney, muscle, and nervous system. Exposure is most often by inhalation due to the gaseous phase at room temperature but cutaneous absorption of the liquid phase also occurs.

Mild exposure produces only transient eye and mucous membrane irritation followed, hours later, by malaise, nausea and vomiting. With acute high level exposure visual symptoms, dysarthria, confusion, delirium, and drowsiness may supervene hours after initial exposure. An even longer latent period prior to development of neurological problems is also a characteristic of the disease. Focal or generalized seizures are commonly reported. Fatal status epilepticus occurs. Myoclonus, amblyopia, pyramidal tract (cortical spinal tract) dysfunction, ataxia, dysmetria, and cog-wheeling have all been reported.[1-5]

Transient and episodic muscle and limb jerking, termed myoclonus, may be present as part of a complex neurological picture following a variety of intoxications, including methyl bromide.[6] Chronic intention or action myoclonus, i.e., coarse limb jerking movement precipitated by the afflicted individual's intention to initiate a purposeful movement or action, has been reported after hypoxia and methyl bromide intoxication.[7] The patient reported here may have suffered transient hypoxia as a result of status epilepticus. However, hypoxia was not judged to be a primary etiology because blood gases were normal shortly after the seizures subsided and because action myoclonus is not a reported complication of status epilepticus.

With chronic poisoning respiratory insufficiency and hepatitis occur. Psychosis may be the initial presentation.[8] Cerebellar dysfunction, pyramidal tract dysfunction, amblyopia, and peripheral neuropathy have been noted.[9] Optic atrophy has been reported.[10]

Postmortem examinations describe brain edema, congestion of the brain and meninges, and petechial hemorrhage with cellular loss in the cerebral and cerebellar cortex. General pathological studies reveal exudative or interstitial pneumonitis, centrolobular hepatic necrosis, hemorrhagic gastritis, and renal tubular degeneration. Although the mechanisms are unknown whereby seizures and myoclonic movements occur, alterations in brain monoamines most specific to norepinephrine depression in exposed animals have been reported.[11] In animal studies dose-related neurobehavioral deficits appear after chronic low-level exposure[12] and lung, liver, kidney, and neurobehavioral dysfunction after acute exposure.[13] On postmortem examination marked stages of acute leukemia, significant loss of Purkinje cells, and nerve cell degeneration in the dentate nucleus and substantia nigra are noted.[14]

Therapy is supportive. Respiratory failure, uremia, gastrointestinal disturbance and seizures have been treated conventionally. Because toxicity occurs after brief exposure, prevention is obtained by a self-contained breathing apparatus whenever methyl bromide is used occupationally.

This case illustrates the danger of occupational exposure to methyl bromide in a house "tenting" procedure not uncommonly used in Florida.

References

1. Moses, H. and Klawans, H.L.: Bromide Intoxication, in Intoxications of the Nervous System, Part I, Vol. 36, Handbook of Clinical Neurology, P.J. Vinken and G.W. Bruyn, (eds.), North Holland Publishing Co., Amsterdam, 1979.
2. Spencer, P.S. and Schaumberg, H.H. (eds.): Experimental and Clinical Neurotoxicology, Williams and Wilkins, Baltimore, 1980.
3. Schuler, H.O.: Poisoning with Methyl Bromide, Dtsch Vtljschr offntl Gesundh-pflege 31:696-700, 1898.
4. Von Oettingen, W.F.: Toxicity and Potential Dangers of Methyl Bromide with Special References to Its Use in Chemical Industry, in Fire Extinguishers and in Fumigation, Nat. Inst. Hlth. Bull. 185, 1946.
5. Greenberg, J.O.: Neurological Effects of Methyl Bromide Poisoning, Indus. Med. Surg. 40:27-29, 1971.
6. Obeso, J.A.; Viteri, C.; Martinez-Lage, J.M., and Marden, C.D.: Toxic Myoclonus, in Advances in Neurology, Vol. 43, Myoclonus, S. Fahn, (ed.), Raven Press, New York, 1986.

7 Hauw, J.J.; Escourolle, R.; Baulac, M., Morel-Marogen, A.; Goulon, M., and Castaugne, P.: Post-mortem Studies on Post-hypoxic and Post-methyl Bromide Intoxication: Case Reports, in Advances in Neurology, Vol. 43: Myoclonus, S. Fahn, (ed.), Raven Press, New York, 1986.

8 Zatuchni, J. and Hong, K.: Methyl Bromide Poisoning Seen Initially as Psychosis, Arch. Neurol. 38(8):529-530, 1981.

9. Kantarjian, A.D. and Shaheen, A.S.: Methyl Bromide Poisoning with Nervous System Manifestations Resembling Polyneuropathy, Neurology 13:1054-1058, 1963.

10. Chavez, X.R.; Hepler, R.S., and Straatsma, B.R.: Methyl Bromide Optic Atrophy, Amer. J. Ophth. 99:715-719, 1985.

11 Honma, T.; Sudo, A.; Miyagawa, M., Sato, M., and Hasegawa, H.: Significant Changes in Monoamines in Rat Brain Induced by Exposure to Methyl Bromide, Neurobehav. Toxicol. Teratol. 4(5):521-524, 1982.

12. Russo, J.M.; Anger, W.K., Setzer, J.V., and Brightwell, W.S.: Neurobehavioral Assessment of Chronic Low-level Methyl Bromide Exposure in Rabbit, J. Tox. Env. Health 14:247-255, 1984.

13. Alexeeff, G.V.; Kilgore, W.W.; Munoz, P., and Wolt, R.: Determination of Acute Toxic Effects in Mice Following Exposure to Methyl Bromide, J. Tox. Env. Health 15:109-123, 1985.

14 Smith, J.K.: Dentatorubropallidoluysian Atrophy in Systemic Disorders and Atrophies, Part 1, Vol. 21, Handbook of Clinical Neurology, P.J. Vinken and G.W. Bruyn, (eds.), North Holland Publishing Co., Amsterdam, 1975

● Dr. Prockop, University of South Florida College of Medicine, Department of Neurology, 12901 N. 30th Street, Box 55, Tampa 33612.

What is your best alternative?

American Medical Association
Department of Practice Management

Presents a NEW workshop
ALTERNATIVE DELIVERY & FINANCING SYSTEMS: Your Options and How to Evaluate Them™

- ☐ Health Maintenance Organizations
- ☐ Preferred Provider Organizations
- ☐ Individual Practice Aseociations
- ☐ Practice Mergers
- ☐ Physician-Hoepital Joint Venturee
- ☐ Creating Your Own Alternative

In-depth one-day eeeeione commence in September, 1986, at nationwide locatione. Complete and mail the Registration Form below or call our epecial REGISTRATION HOT-LINE NUMBER COLLECT 312/645-4958

Explore your options

- Components of alternative systems
- Advantages and disadvantages of various systems
- Evaluating contracts
- How to co-exist successfully with other systems
- Develop a business plan
- Implement needed changes in your practice
- And more.

Get the facts so you can make an informed choice.

AMA — American Medical Association

REGISTRATION FORM—Alternative Delivery & Financing Systems

☐ AMA Member or staff employee of member
Regular Price $360 Team Price* $290

☐ Non-Member
Regular Price $460 Team Price* $390

☐ Payment Enclosed $_____
Please make check payable to the American Medical Association

Charge my credit card ☐ MasterCard ☐ Visa

Acct. No._____ Exp. Date_____

Signature_____

Name_____

Specialty/Title_____

Address_____

City_____ State_____ Zip_____

Office Telephone_____

Team Participant_____

Additional Team Participant_____
Please list names, specialties, and membership status of other registrants on an additional sheet

Please recognize my practice as
☐ Solo
☐ Partnership (2 physicians)
☐ Group (3 physicians or more)

TO REGISTER complete this form, cut along the dotted line, and mail in an envelope along with your payment to:

American Medical Association
Dept. of Practice Management
535 North Dearborn Street
Chicago, Illinois 60610
ATTN: Registrar

*Team price applies to each additional person after the first registration, at the regular price, who attends the same program
Prices subject to change without notice

Check choice of workshop location and date:

Phoenix, AZ ☐ Friday, October 10	**Atlanta, GA** ☐ Friday, October 24	**Dearborn, MI** ☐ Wednesday, September 17* ☐ Friday, November 14	**Buffalo, NY** ☐ Friday, September 5 ☐ Wednesday, November 5	**Tulsa, OK** ☐ Friday, October 17
San Francisco, CA ☐ Wednesday, November 19	**Chicago, IL (AMA)** ☐ Thursday, September 18 ☐ Saturday, October 18 ☐ Thursday, November 6	**Kansas City, MO** ☐ Friday, September 26 ☐ Wednesday, November 5	**New York, NY** ☐ Wednesday, September 3 ☐ Friday, November 7	**Nashville, TN** ☐ Wednesday, October 8
Denver, CO ☐ Wednesday, September 24 ☐ Friday, November 14	**New Orleans, LA** ☐ Friday, October 10	**St. Louis, MO** ☐ Wednesday, September 24 ☐ Friday, November 7	**Syracuse, NY** ☐ Friday, September 5	**Austin, TX** ☐ Wednesday, October 15
Ft. Lauderdale, FL ☐ Friday, October 24	**Baltimore, MD** ☐ Friday, September 19 ☐ Wednesday, November 12	**Reno, NV** ☐ Wednesday, October 8	**Raleigh, NC** ☐ Wednesday, October 22	**Salt Lake City, UT** ☐ Wednesday, October 15
Orlando, FL ☐ Wednesday, October 22			**Cincinnati, OH** ☐ Friday, September 19	**Seattle, WA** ☐ Wednesday, November 12

MAIL TODAY or CALL COLLECT 312/645-4958

4309-CB24-REV



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR



Health Care At Its Best: Air Force Medicine

Air Force medicine is one of our best benefits, and, with your help, we'll keep it that way. The Air Force needs physicians such as you to become members of our health care team.

Most administrative responsibilities are in the hands of others, giving our physicians the time to give their full attention to the patients' needs. Our hospitals are staffed with dedicated, competent professionals.

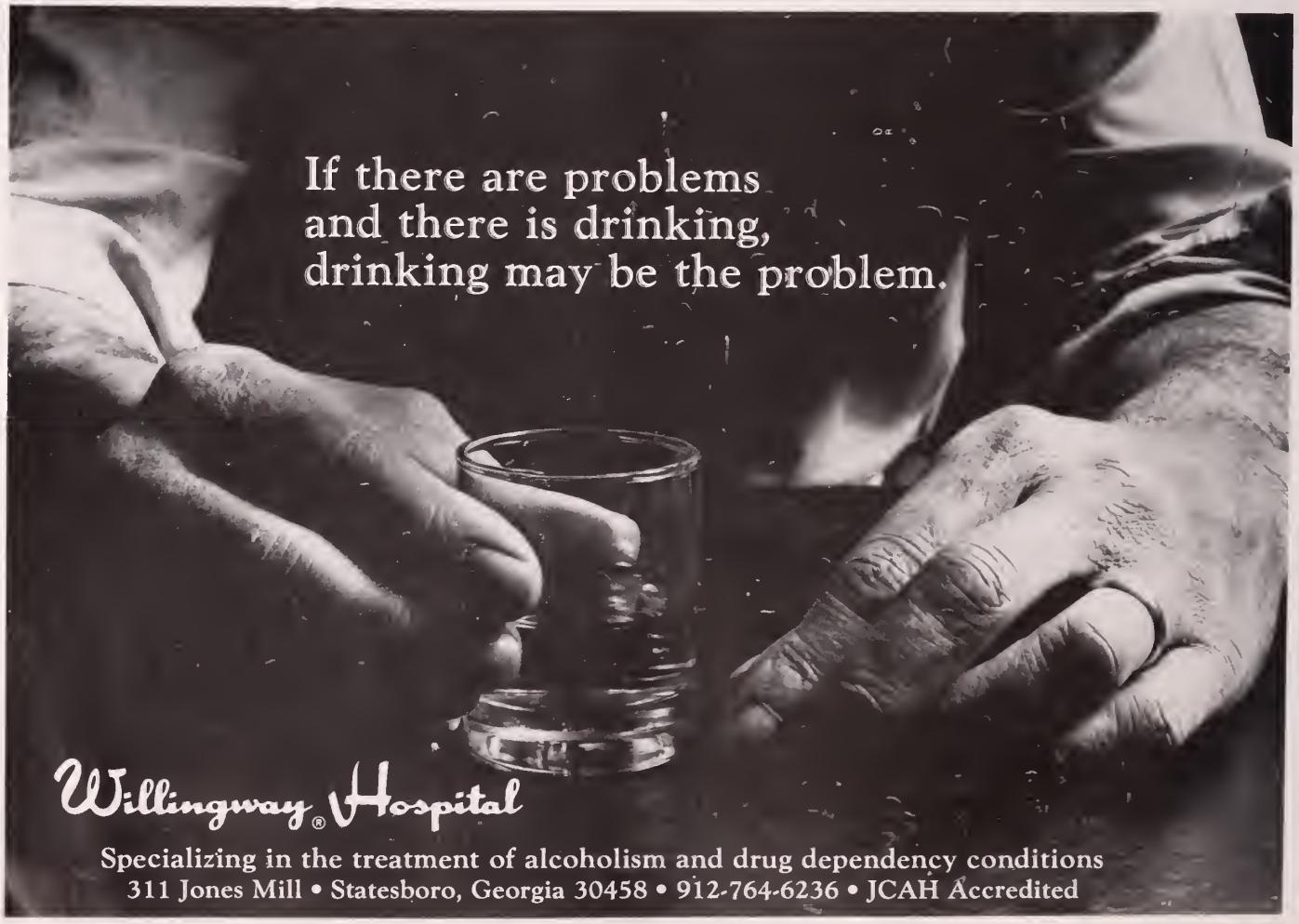
You'll find you will have time for your family, and to keep abreast of the latest methods and technologies that you don't have time for now. We also offer unlimited professional development and financial security.

If you're considering a change, consider Air Force medicine. To find out more about Air Force medicine, contact your nearest Air Force recruiter. Experience health care at its best.

Contact: Coral Gables — (305) 444-0503; Gainesville — (904) 378-5102; Tampa — (813) 722-5014; EOE.

AIR FORCE

A great way of life.





To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
with acetaminophen 500 mg

Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics, therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother
Pediatric Use: Safety and effectiveness in children have not been established
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur, they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

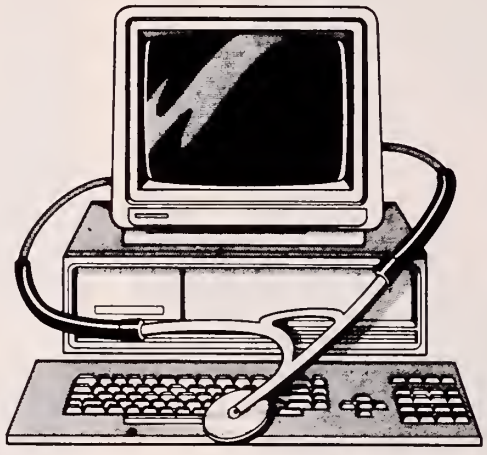
Revised, April 1982

knoll® KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

SPECIAL ARTICLE

Democracy and health care

Trends in three kindred western nations: Britain, Canada, and the United States

Richard J. Feinstein, M.D.

In a representative democracy such as ours, it is often quite difficult to determine whether elected representatives are actually carrying out the will of the electorate through their legislative actions. Their votes on important legislative issues may in fact reflect this will or may represent a misguided perception of what the electorate really wants and the repayment of favors to special interest groups and campaign supporters.

Even if elected leaders do listen to the electorate, legislative actions can be greatly influenced by which individuals and groups they listen to. America, perhaps more than other nations, is a tribal society composed of a confederation of groups who seek their own economic and political interests, as well as the patriotic and less tangible goals of the nation itself. Our society is based on commerce, wealth, and the pursuit of materialistic success.

Special interest groups are delineated on the basis of religion, race, ethnic origin, occupation, location, and gender. The interests of one group quite often run exactly counter to the interests of others, and elected leaders must try to come to grips with such conflicts and support legislative policies that somehow produce the greatest good for the greatest number. A major goal of all elected officials is to remain in office and, when possible, ascend to more powerful positions within the bureacracy.

The Author
RICHARD J. FEINSTEIN, M.D.
Dr. Feinstein is Clinical Associate Professor of the Department of Dermatololgy at the University of Miami School of Medicine, Miami.

As physicians in the United States, we are just one of the thousands of tribes who seek support through access to the legislative process. The medical profession is composed of a half-million individuals, representing less than one half of one percent of the nation's population of 250 million. Our tribe is itself inhomogenous because, as physicians, we are also members of other groups through affiliations based on religion, race, national origin, medical school, and geographic location.

Physicians, like clergy, are relatively unique among special interest groups in that we profess not only an interest in our own well-being but in our clients, the patients, as well. We claim an intense loyalty to patients in our quest for legislative assistance from elected leaders, who may choose to accept our appeals for assistance in the belief that we are in fact the legitimate representatives of our patients who sometimes have no voice themselves. On the other hand, elected officials may believe instead that our supplications are merely the self-serving demands of a special interest group which is interested only in itself, and which in reality has become completely alienated from the needs of patients.

From the distance of time and space, it now seems obvious that elected officials in Massachusetts chose to listen directly to the Senior Action Council and other consumer groups rather than the State Board of Registration in Medicine and the Medical Society of Massachusetts when, on July 9, 1985, the Senate in that state voted (39-0) to approve passage of Senate Bill 217, which requires all physicians, as a condition of licensure, to accept Medicare assignment on all patients and to accept what Medicare allows as payment in full for professional services.[1] The House followed suit, voting unanimously (151-0) on October 30, 1985, and Senate Bill 217 became law

in Massachusetts on February 10, 1986. The law has already withstood one court challenge by the Medical Society of Massachusetts.

One has to wonder whether the unanimous vote in both the Senate and House of Representatives implies that every single citizen of the Commonwealth of Massachusetts is in favor of Senate Bill 217. Did every member of every other tribe — the elderly, the poor, the business class, the working class, and the very wealthy — unite philosophically against the interests of one other group, physicians, to impose what all physicians believe is a restrictive and unfair law? Are physicians in Massachusetts so distained by others and so isolated from the state's electorate and elected representatives, patients, every one of them, that Senate Bill 217 was enacted unanimously and without protest from any other group?

Great Britain • Was the will of the entire population of Great Britain reflected in Lord Beveridge's report to Parliament in 1942, which established the ground work for implementation of the National Health Service after World War II? The Labor Party, which has always pursued socialist policies and the interests of the common man, was in power when the NHS was begun. Even though Conservative administrations have tried to redress the balance to some degree when they were in power, both parties have been totally committed to the NHS since the onset.

Is it possible that no group in Great Britain opposed implementation of the National Health System or now opposes its continued existence? Was the creation of the NHS a resounding defeat for British physicians and the British Medical Association, as was the implementation of Senate Bill 217 in Massachusetts, or was the health plan implemented during those years of economic privation following World War II because many physicians, including many prominent leaders of the BMA themselves, favored the proposed health plan's socialistic remedies? The basic premise of the NHS has remained the same over the past 40 years: "a comprehensive health service that is available to every citizen and free at the time of use."[2]

The Labor party has always been opposed to any private practice and when the Conservatives returned to power in 1979, Labor legislation was repealed that had outlawed private-pay beds at NHS hospitals. The building of new private hospitals began, providing an incentive to private health insurance which in turn encouraged the conservative government's central policy review staff to propose the replacement of the NHS with a system of private health insurance, like that found in the United States, as a way of reducing public spending on health care.

The proposals were not pursued, however, because it was considered to be politically unacceptable and not financially beneficial to the government and by 1982 the growth of private health insurance had leveled off in Great Britain. This was attributed to the escalation of insurance premiums at a rate that was far higher than the rate of inflation, which in turn was thought to be related to the increased number of claims and cost of medical care, particularly in the new private hospitals. "It is interesting to observe how difficult cost containment may be with a private insurance based system."[3]

Did the Beveridge report and the implementation of the National Health System really represent the will of the entire electorate, or merely of the elected members of Parliament? The two major political parties, Conservatives and Labor, representing completely opposing views of the degree of government participation in providing services to the citizens, both favored the continued existence of the complete government control of the health care industry.

One must conclude that most people in Great Britain are generally happy with the health care system there, regardless of what the physicians or their associations think about it. Are the citizens of that nation unusually receptive to socialist ideology?

Canada • Are the citizens of Canada, our neighbors to the north, uniquely receptive to socialist tendencies as well? The evolution of universal health insurance in Canada dates to 1914 when the province of Saskatchewan introduced a Municipal Doctor Plan. By 1961 all ten provinces had hospital insurance plans and by 1966, with the passage of the Medical Care Act, physicians' services were included as well, establishing a publicly administered universal health insurance program for all medical services. "By 1971, all the provinces had adopted hospital and medical insurance programs that met the basic conditions set out by Parliament to qualify for federal funds covering 50% of the program's costs."[4]

Canada's ten provinces have broad authority to tax their citizens, and they spend more in total tax revenues than the central government. The federal government uses the mechanism of cost sharing to exert control over aggregate health care expenditures. "Unlike the United States, where federal health policy is hammered out in negotiations between the executive and legislative branches, the critical dialogue in Canada pits federal ministers against their provincial counterparts."[5]

By 1977, in response to rapidly rising health costs and the central government's open ended financial contributions to the provincial health plans, Parliament changed the method of cost sharing by enacting the Federal-Provincial Fiscal Arrangements Financing Act and in the mid-1970s, the federal government also introduced a national program of controls of incomes and price. Extra billing became more common by physicians when the freeze was lifted, because of tighter controls over approved fees and the prior freeze on fees and incomes. Physicians used extra billing, the practice of asking patients for payment in addition to

the government allowance, as a way to recoup the income they had lost under the economic controls. "Some provinces permitted the practice because they reasoned that it would shift to consumers a share of the expense of medical services and reduce pressure for sizable increase in physician's fee schedules."[6] Patients were free to choose any physician they preferred, including those who did not extra bill.

Concern grew, especially in Ontario, the most populous province, and in Alberta, the most conservative, that extra billing was eroding the easy access to health care so treasured by Canadians. A commission on extra billing, chaired by ex-Chief Justice Emmet Hall of Saskatchewan, an important figure in the initiation of the entire Medicare system, released a report in 1980 criticizing extra billing and in 1983 the Liberal government of Pierre Elliot Trudeau proposed the Canada Health Act, reasserting federal power over provincial plans.

"The provinces and the Canadian Medical Association strongly opposed the ban on extra billing and hospital user fees on the ground that the restrictions would infringe on the rights of physicians and of regional governments. Nevertheless, Parliament unanimously passed the act in the spring of 1984."[7]

One observer in Parliament during the debate and vote on the bill comments: "Not only were the liberals and, predictably the NDP (socialist leaning New Democratic Party), voting yes, but one by one every Tory in the House, including Brian Mulroney, the leader of the opposition, was voting yes, too. Many of our members were incredulous. Then it dawned on them: the public opinion polls. The Tories realized that public opinion was so solidly behind what was being proposed (Canada Health Act) that they dared not vote the courage of their political convictions. When the final vote was counted not a single Tory had voted no."[8]

"In the almost two years since Mulroney became prime minister, the federal government has moved to implement fully the Canada Health Act, including the provisions to ban extra billing. In Ontario, the ruling Liberal party and its supporters voted on June 20, 1986 to prohibit extra billing in the province. If they had failed to do so by April 1987, the province would be unable to recoup some $4.4 million monthly from the federal government."[9]

The conflict between doctors and government is not only about extra-billing; it is about control over the health care system, and the amount of money governments are prepared to dedicate to that system.

"Ontario's physicians have been handicapped in their struggle with the provincial government because public opinion overwhelmingly favors the prohibition of extra billing. An editorial published May 31, 1986 in the *Globe and Mail* of Toronto, which characterizes itself as 'Canada's national newspaper,' reflected this view. In waging war against extra billing, the newspaper asserted, physicians are 'fighting for a goal that they will not achieve and should not achieve. The conflict between doctors and government is not only about extra-billing; it is about control over the health care system, and the amount of money governments are prepared to dedicate to that system. Hard financial choices remain to be made about the limits of service.'[10]

Robert G. Evans, a well known Canadian health care economist, summarized the dilemma in Canada during a recent interview: "Increasingly, Canada is running into the contradiction that was built into the health insurance plan at its creation. By that I mean there is a basic conflict in a policy that says government must control its budget, health care funding must be universally available, physicians must retain their professional autonomy, and consumers must have free choice of providers. There is no obvious mechanism for resolving this conflict, and no politician wants to tear down the system that is in place. This dilemma, I might add, is not unique to Canada. In one way or another, it is prevalent throughout the Western world."[11]

United States • Despite the presence at different times of conservative or liberal administrations in Canada and Great Britain, government control of health has continued in those two nations. It continues because the electorate has determined that it wants reduced costs and greater accessibility to health care, despite limitations imposed and the increased likelihood of inefficient bureaucratic control of the process by the federal government. It appears that it is the legitimate right of government to establish priorities for the use of scarce resources, including health care and health care expenditures, and to inhibit the natural inclination of individuals to overutilize these resources, especially at the expense of society.

Governments must be concerned with finances, as we all are, and elected leaders are always interested in reducing costs and saving money, but they also have an intense interest in the political ramifications of every action they take. They must weigh the issues and determine what is best for the majority at the least expensive cost, both as a mechanism for maintaining an efficient government and for increasing the likelihood of their continuation in power.

The situation in the United States is becoming increasingly similar to the one which existed in Canada, and to a lesser degree to Great Britain. Great dissatisfaction has developed with the health care system in this country, especially with the fee-for-service and third party payment plans. This dissatisfaction has been voiced by leaders of unions

and industry alike, who have become increasingly intolerant of the costs of providing health care to their constituents, but we must conclude that the dissatisfaction has its origin with the majority of the population itself, who are finding their health care expenditures rising faster than inflation or their ability to sustain the rising costs. The growing percentage of the population who are senior citizens finds an increased actual dollar amount and a higher percentage of their incomes going to health costs, despite the obligation of Medicare to pay most of those costs. The portion that Medicare does not pay is in many instances higher than what the beneficiaries can afford to pay. Many of the elderly have been duped by those selling insurance intended to cover the portion for which Medicare is not responsible.

As the annual cost of health care has risen to its present level near 11% of the Gross National Product, $400 billion annually and more than one billion dollars each day, a watershed was reached in the willingness of the population to tolerate the situation. In addition, despite the enormous annual expenditure of public and private money for health care, more than 10% of the population has no health insurance and an additional 10% lacks what could be considered adequate insurance, reducing their access to health care considerably. Even health care providers, like the American Hospital Association (AHA), are finding the present situation intolerable. AHA advertisements now address the burden of medical indigence on hospitals, stating in their ads in magazines and newspapers that hospitals provide nearly seven billion dollars a year in uncompensated services to individuals who have inadequate or no health insurance.[12]

Our federal government, despite the present conservative Republican administration, is like all other governments in its desire to reduce government spending, while at the same time it attempts to create peace and tranquility among the population and improve its likelihood of maintaining a power base within the electorate.

States have also had to deal with the problem of public dissatisfaction with high health care costs and some, like Massachusetts, have enacted legislation to limit physician fees and other provider costs. The legislative action was unanimous in that state because those leaders, like Brian Mulroney had done in Canada, read the opinion polls and realized the degree of intense anger and frustration that most of their constituents feel about the present health care system. Four other states are considering legislative action similar to what was enacted in Massachusetts.

The federal government has imposed rate rollbacks for Medicare Part B, as well as the Diagnosis Related Group (DRG) payment system to standardize hospital Part A charges for federal patients. They instituted professional peer review organizations to assure quality of care and as a mechanism to decrease the waste of federal monies allocated for health care use. Congress, through HCFA, the Health Care Financing Administration, has attempted to entice all physicians to sign up as fully participating in their acceptance of Medicare Part B assignment. If physicians do sign up, however, they lose the leverage provided by their patients who complain to elected officials when problems arise with the Medicare system. We have seen time and time again that the government is no longer likely to listen to physician complaints. Congress has also imposed a fee freeze for providers and an additional one percent reduction in Part B payments to save money spent on health care. Additional Part B cuts are expected, as well as increasing deductibles for both hospitals and physicians services.

Unlike Canada and Great Britain, the U.S. federal government has not yet assumed further control of the health care financing and delivery systems. It has gone along instead with private efforts, such as the development of HMOs (health maintenance organizations) and PPOs (preferred provider organizations) as methods of reducing the total annual cost of health care for this nation. Despite great public concern about our present health care system, the government has not made it a priority issue and has chosen only to express its concern by supporting and financing the development of alternative health care systems that propose to reduce total health costs, federal participation in those costs, and the rising dissatisfaction of the electorate.

Unlike Canada and Great Britain, the U.S. federal government has not yet assumed further control of the health care financing and delivery systems. It has gone along instead with private efforts, such as the development of HMOs and PPOs as methods of reducing the total annual cost of health care for this nation.

Many physicians and their associations express dissatisfaction with these new plans but offer no other ways to deal with the criticism of the existing system that is being expressed by such divergent groups as major manufacturing corporations, like Chrysler and General Motors; labor unions, like the United Auto Workers and Teamsters; and municipalities and governments, like the State of Florida and Metropolitan Dade County. Each of these entities, representing millions of individual citizens, has expressed displeasure with the way in which health care in this nation is being provided and financed by seeking alternative methods, such as HMOs and PPOs.

Many physicians continue to oppose these new plans, labeling themselves as the last bastions of

freedom and caretakers of the rights of their patients. While individual physicians may be, as they profess, caring and conscientious consumers of scarce health care dollars who are interested only in the welfare of their patients, all physicians and all patients are not so similarly imbued with concern for the expenditure of health care dollars, especially when those dollars are paid for by a distant and anonymous third party, be it the federal or state government or an apparently wealthy insurance conglomerate.

And while these individual physicians profess to care about private practice, professional freedom, and their own patients' well-being, they neglect to realize that their patient pool is shrinking as fewer and fewer Americans are capable of paying for their services. They also forget about the 70 million or more Americans who are inhibited from visiting physicians because of inadequate health insurance or personal resources.

Unfortunately, many of us have been so consumed with protecting the rights of the profession that we have lost sight of the need to protect patients and try to ensure proper health care for all Americans. Because of this, we have not instituted any new policies which would improve health care and the financing of that care for most Americans. We have merely reacted to plans introduced by governments or other forces, like health care entrepreneurs, who seek changes in the American health care system for a variety of reasons, only few of which have the patients' real interests at heart. The government's main concern is saving money, and the entrepreneur's main interest is in making money for himself and his share holders.

It is also apparent that the federal government has no actual health care policy, merely a haphazard desire to keep the system working without offending too many important players. Government leaders try to keep the system functioning while they now also try to moderate or reduce costs without alienating major constituents. The same dilemma that Robert Evans observed in Canada is being played out here: "a basic conflict in policy that says government must control its budget; health care funding must be universally available; physicians must retain their professional autonomy; and consumers must have a free choice of providers."[13]

The federal government, according to a *Miami News* editorial, places "Medicare patients in a callous vise" by reducing Medicare benefits and denying home health care benefits. "Reagan's bureaucrats could not make the lives of the elderly poor so miserable by accident; they must be doing it on purpose."[14] At the very same time, the National Task Force on Organ Transplantation has recommended that the government begin funding liver transplants in adults, and immunosuppressive medication for transplant patients who cannot afford this expensive treatment.[15] Such policies widen the gap between those who receive health care benefits and those who do not and point to the naivete of our national policy toward health care financing.

No nation, not even the United States with its enormous wealth and propensity for extravagance and waste, can continue to promise everything to everyone: a stable federal budget with an end to deficit spending and the federal debt; professional freedom and high fees to physicians and other health care providers; and universal access to all health care services for all beneficiaries. We cannot provide organ transplantation at public expense while also allowing home health and nursing home care for 25 million senior citizens, without having to spend more money than is available, and more than most citizens are willing to support through taxation and insurance premiums.

Physicians must initiate and endorse health delivery and financing plans that benefit a majority of the population, even though we may have to compromise some of our professional autonomy and income to accomplish this end. We must allow professional review and quality control organizations, administered by physicians, to ensure that proper care is being delivered at a reasonable cost and without excessive waste, because unfortunately there are physicians who are incompetent and wasteful. We must consider ways to guarantee better access to health care for the 70 million Americans who presently have no care or diminished access to that care. We must concede that the health care system in the United States can no longer be everything to everyone, especially to physicians. We can no longer consider ourselves so special that we must thrive at the benefit of society and our patients; patients who no longer respect us and are no longer willing to accept our extravagances under the pretense of looking out for their interests along with our own.

Physicians must initiate and endorse health delivery and financing plans that benefit a majority of the population, even though we may have to compromise some of our professional autonomy and income to accomplish this end.

If physicians do not accept the inevitable fact that the health financing and delivery systems in this nation will change, and if we do not look to keep control within the private sector with our participation, then the system will change without our input and even without our acquiescense, and it may be changed by those who are our adversaries. If physicians do not cooperate with private initiatives to decrease the cost and increase the availability of health care to all Americans, then private initiatives might eventually fail, perpetuating the dissatisfaction of a

majority of Americans with the cost and availability of the system. If that does happen, then the federal government of this nation, as did the federal governments of Great Britain and Canada, will assume greater and perhaps even complete control of health care even in this richest nation on earth.

We must not allow "socialized medicine" to become a reality in this nation, because it will most certainly herald the advent of the kind of social and economic mediocrity that is prevalent in Great Britain, Sweden, and other nations in which government control has destroyed ambition and individuality. On the other hand, we must also prevent selfish businessmen, a unique American health care phenomenon, from abusing physicians and patients under the guise of cost control, because if they are allowed to rape the system, the public outcry that inevitably will follow will force the government, as the only perceived legitimate representative of the people, to assume complete control.

It is not too late; health care is at the crossroad now and physicians must assume leadership so that it proceeds in the direction that is best for the nation as a whole, including our patients and ourselves. We should return to our role as our patients' only legitimate representatives and make their goals our goals.

References

1. Morse, Leonard. Why I Resigned from the Board, Massachusetts Medicine, March-April, 13-14, 1986.
2. Lister, John: Shattuck Lecture, The Politics of Medicine in Britain and the United States, NEJM, Vol. 315, No. 3, July 17, 1986, pgs. 168-174.
3. Ibid
4. Iglehart, John: Health Policy Report, Canada's Health Care System, NEJM, Vol. 315, No. 3, July 17, 1986, pgs. 202-208.
5. Ibid.
6. Ibid.
7. Ibid
8. Johnston, D. Up The Hill, Optimum Publishing International, 1986.
9. Iglehart, Ibid.
10. Ibid.
11. Ibid.
12. American Medical News, July 25, 1986, page 31.
13. Iglehart, Ibid
14. Miami News, July 30, 1986, page 8A
15. American Medical News, July 25, 1986, page 1

● Dr. Feinstein, 3661 S. Miami Ave., Miami 33133.

Legality of physician referral of patients to health care facilities owned by the referring physician

John Michael Register and Leon J. Wolfe

In the past few years physicians in Florida have become increasingly involved in owning and operating new forms of health care facilities. In a typical situation, a group of physicians ("Investing Physicians") will directly or indirectly (through a corporation or a partnership) own and operate a hospital, clinic or diagnostic/surgical center (a "Facility"). The Investing Physicians then often refer patients to the Facility. The Investing Physicians do not receive any form of compensation merely for their referrals; rather, if the Facility has a net profit, they receive a return on, or increase in the value of, their investment. Conversely, the Investing Physicians suffer a decrease in the value of their investment if the Facility incurs a net loss.

Recently, there has been concern that physicians who refer patients to a Facility which they own may be in violation of the Florida law[1] prohibiting kickbacks to physicians for making referrals.[2] At present the law is ambiguous and, if strictly construed, a physician could conceivably lose his license[3] for referring patients to a Facility in which he has an ownership interest.

This article first discusses the beneficial effect that physician investment in Facilities could have on the cost of medical services in Florida. It then examines the present law and discusses whether physicians investing in a Facility violate the statute that prohibits physicians from receiving kickbacks for making referrals or exploiting patients for financial gain. It concludes that although the statute is ambiguous, such construction would not be warranted. This article then offers suggestions for physicians investing in Facilities under the present law to best protect themselves. Finally, the article proposes revisions in the existing law to encourage physicians to invest in Facilities.

The Authors
JOHN MICHAEL REGISTER
LEON J. WOLFE
Mr. Register is a lawyer in Tampa, while Mr. Wolfe, also a lawyer, is with Valdes-Fauli, Cobb and Petrey, P.A., Miami.

A. Effect on patients of physician investment • In the past few years there has been a rapid rise in the number of Facilities and in particular the number of free-standing medical clinics.[4] The impetus for the development of these clinics results from demands from government officials, health insurance carriers and consumers for less costly medical treatment.[5] These clinics are designed to provide many of the same services as hospitals but without the expense and inconvenience because they are not burdened with the hospital's expensive physical plant and overhead. Thus, they offer patients and their insurance companies significant cost savings. Blue Cross/Blue Shield recently announced that hospital usage would decrease over 7% in 1986 as a result of free-standing clinics.[6]

As more clinics open, the medical marketplace becomes increasingly more competitive. Patients in need of outpatient treatment will have a choice of where they wish to go. Clinics and hospitals will compete for these same patients. The result of this competition will be market pressure for the clinics and hospitals to provide the best possible treatment at the lowest price. The savings can be dramatic. A comparison of fees for the care of a sprained ankle by hospitals and clinics in California shows that the hospitals charged an average of $150 while the clinics were able to provide comparable service for $75.[7]

Physicians should be encouraged to invest in these Facilities. The competition generated by allowing physicians to open Facilities and then refer patients to them should increase downward pressure on medical costs. Fear of malpractice suits and market repercussions should keep the quality of medical care high. Some lawyers, however, are hesitant to let physician clients enter this competitive health industry arena for fear of violating Florida law. The next section discusses the present law.

B. Analysis of the physician investor-facility relationship: Section 458.331 • Section 458.331 of the Florida Statutes[8] contains two provisions that could subject an Investing Physician to disciplinary action by the Board of Medical Examiners (the "Board") for referring a patient to a Facility in which the Investing Physician has an ownership interest. Section 458.331 (1)(j) restricts:

> Paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers or pharmacies. The provisions of this paragraph shall not be construed to prevent a physician from receiving a fee for professional consultation services.

Section 458.331(o) broadens the scope of Section 458.331(1)(j). It restricts:

> [e]xercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or of a third party which shall include, but not be limited to, the promoting or selling of services, goods, appliances, or drugs and the promoting or advertising on any prescription form of a community pharmacy unless the form shall also state "This prescription may be filled at any pharmacy of your choice."

Neither provision heretofore has been interpreted by a Florida court with respect to physician ownership of a Facility. Thus, the legality of physician ownership of a Facility with respect to patient referrals must be determined by Florida case law on predecessor statutes to the current Section 458.331, the language of the provisions, and analogy to other areas of the law vis-a-vis prohibitions against commissions, bonuses, kickbacks, or rebates for referrals within an industry.

1. Florida Case Law

Lester vs. Department of Professional and OCC Regulation[9] is the only reported case in Florida concerning an allegedly illegal business arrangement between a physician and a provider of health care services or goods. In *Lester*, the Board brought a disciplinary proceeding against a physician for allegedly receiving kickbacks from a hospital. The physician had a contract with the hospital whereby he received 4% of the gross receipts of the hospital and a fixed monthly compensation of $1,400 for acting as a consultant to the owner of the hospital in the management, planning, and operation of the hospital. In the proceeding, the Board alleged the contract was merely a cover-up for kickbacks the physician received for referring patients to the hospital.

The Board charged[10] the physician with violating former Section 458.1201(m).[11] This section stated:

> Denial, suspension, revocation of license; disciplinary powers —
>
> (1) The board shall have authority to deny an application for a license or to discipline a physician licensed under this chapter or any antecedent law who, after a hearing, has been adjudged unqualified or guilty of the following:
>
> (m) Being guilty of immoral or unprofessional conduct, incompetence, negligence, or willful misconduct. Unprofessional conduct shall include any departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice in his area of expertise as determined by the board, in which proceeding actual injury to a patient need not be established; when the same is committed in the course of his practice, whether committed within or without this state.

The court ruled that the Board could not discipline the physician under the statute. Applying a strict construction because of the penal nature of the statute, the court stated that the proscription against the "kickbacks" received by the physician must be specifically included in the statute before the physician could be disciplined.

The court further stated that "[h]ad the legislature intended to include kickbacks or rebates as within the term 'unprofessional conduct'. . .it could have readily done so by further amendment of the Medical Practice Act in 1976."[12] This judicial pronouncement perhaps prompted the legislature to amend the Medical Practice Act to specifically prohibit the conduct of the physician in the *Lester* case. Thus, *Lester* demonstrates that the Board — now with clear legislative approval — can discipline a physician for receiving a kickback. The case, however, does not shed light on the meaning of "commission, bonus, kickback, or rebate, or engaging in a split-fee arrangement" as used in the present statute.

2. Analysis of the Statute

Section 458.331(1)(j) prohibits the "paying or receiving of any commission, bonus, kickback or rebate, or engaging in any fee-arrangement split . . . for patients referred to providers of health care goods and services . . ."[13] This language appears to prohibit only making or receiving payments for the mere referral of a patient to a provider of health services. It can be argued that Investing Physicians would not be receiving payment for a referral; rather, if the Facility earns a profit, they would receive a return on or increase in the value of their investment in the Facility.

Furthermore, investment in a Facility is distinguishable in two other ways. Unlike a traditional kickback arrangement in which the referrer is guaranteed a certain payment for each referral, Investing Physicians have no guarantee of such payment. Any profit the Investing Physicians may make would be contingent upon the success of the Facility.

Investment in a Facility also differs from a traditional kickback in that the number of referrals an Investing Physician makes only indirectly bears on his financial success in the Facility. The profit by each "referral" inures to the benefit of the entity owning the Facility (the "Owning Entity") which then distributes it without reference to the number of referrals an Investing Physician has made.

On the other hand, the language of Paragraph (j) concerning "commissions, kickbacks, and rebates" could be construed to include a return on investment in the Owning Entity. The Board might decide to ignore the form of the Investing Physicians' arrangement and view any financial gain for the referral of patients to a Facility as a "commission, kickback or rebate." The fact that any financial gain to the Investing Physician would be related only to his equity share in the Facility, and not to the number of patients actually referred, would have to be seen as irrelevant under such a construction of the statute. Under this interpretation of the law, an Investing Physician would be in violation of the statute if he referred a single patient to the Facility.

Section 458.331(1)(o) prohibits the exploitation of a patient or client for financial gain by the promoting or selling of services, goods, appliances, or drugs.[14] By using the term "exploit," this section can be read to imply either (1) that it prohibits the sale of unnecessary drugs or medical services from which the physician receives financial gain; or read broadly, (2) that it prohibits the sale of any drugs or medical services from which the physician receives any financial gain. Under the first interpretation, a referral by an Investing Physician apparently would not be prohibited as long as the treatment provided is necessary for treatment of the patient. If the treatment is necessary, then it appears that no exploitation of the patient would result.

If the prohibition is interpreted more broadly, then a referral by an Investing Physician may be prohibited under Paragraph (o). The Investing Physician, by referring the patient to the Facility for testing, would be promoting the sale of a service for (potential) financial gain, even though the gain, if any, would come indirectly in the form of a return on his investment.

The one reported case that cites Section 458.331(1)(o) lends support to the argument for a narrow interpretation of the term "exploit." That case, *Sternberg vs. Department of Professional Regulation*,[15] involved an allegation by the Board that Dr. Sternberg violated Section 458.331(1)(o) by performing "redundant and, therefore, unnecessary tests" and then charging his patient for the redundant tests.[16]

The impropriety alleged, however, was that Dr. Sternberg performed and billed for unnecessary tests. As the court points out, "[t]he hearing officer correctly observed that Chapter 458, Florida Statutes, does not prohibit a physician from setting his own fees, and that overcharging, per se, is not prohibited by law."[17] Thus, reaping a financial gain from the provision of health care services is not illegal as long as the services provided are not unnecessary.

3. Prior Interpretation of the Meaning of "Kickback" and "Exploit"

Although the Florida statute uses the phrase "commission, bonus, kickback or rebate, or engaging in fee splitting. . .," statutes proscribing this type of conduct generally use the words "bribe," "kickback," or "rebates." For example, several courts have interpreted "kickback" as it is used in the Social Security Act.[18] These statutes prohibit the receiving or paying of kickbacks for referring individuals to providers of goods or services which are to be paid for out of Medicare or Medicaid funds.[19]

In construing "kickback," most courts follow the Seventh Circuit's decision in *United States vs. Hancock*,[20] which looked to the common meaning of kickback because it was not defined in the statute. In *Hancock*, two chiropractors were accused of violating the Medicare kickback law by soliciting and receiving a fee for the referral of patients' tissue samples to a particular laboratory. The court in *Hancock* defined kickback as "a percentage payment. . . for granting assistance to one in a position to open or control a source of income."[21]

Hancock and other cases[22] prosecuted by the United States government under the Social Security Act involved physicians receiving a fee for using or purchasing a certain product or service from an independent company, such as a laboratory for a blood analysis. No reported cases were prosecuted under this statute in which a physician had an ownership interest in the company or provided some consultation or service. Thus, although a return on an investment could fall within the *Hancock* definition because the physicians will be "granting assistance" (i.e., making the referral) for compensation (although indirect in the form of an equity return), it most likely does not encompass referrals from one in the situation of an Investing Physician because the financial return, if any, is instead based on his pro rata ownership in the Owning Entity.

Although a similar analogy for "exploitation" could not be found, its common meaning supports the more narrow interpretation that would not encompass an Investing Physician. Webster[23] defines "exploit" as "1. to make use of, turn to account; utilize productivity; 2. to make unethical use of for one's own ad-

vantage or profit; specif., to make profit from the labor of (others). . ." The Florida legislature most likely intended the latter definition to apply to "exploit." Thus, as long as the patient is in need of the treatment, referring a patient to the Facility would not be unethical under Section 458.331(o) of the Florida Statutes.

C. Safeguards under existing law — analogy to Real Estate Settlement Procedures Act • The Real Estate Settlement Procedures Act[24] ("RESPA") provides a good analogy to the legality of intra-industry referrals where the referrer receives something of value for making a referral. RESPA prohibits the giving or receiving of value for referring a client to another company or service within the real estate industry. For example, RESPA prohibits a real estate broker from receiving a referral fee or kickback for referring or requiring a client to use a particular title insurance company if the real estate broker does not perform actual services for the title insurance company.

RESPA, however, provides an exception to this rule. If a person owns or controls two companies offering real estate services refers a client to the second company, he can receive a return on his ownership interest if certain disclosures are made to the client. These disclosures include: (1) the existence of a controlled business arrangement; (2) a written estimate of the charge or range of charges of the provider of the service to which the person is referred; (3) a choice to the person who is being referred to the provider to use any particular provider of the service; and (4) that the owner of the "controlled business arrangement" does not receive anything of value for the referrals from one unit to another unit of his "controlled business arrangement" except a return on the ownership interest or franchise relationship and reasonable compensation for services actually performed, and that no one else receives or gives a related fee, kickback or "thing of value" from the arrangement unless the fee is reasonable and is for services actually performed.[25]

The analogy to RESPA will be beneficial to Investing Physicians if they decide to make certain disclosures to the patient to safeguard against a broad interpretation of the statutes or if they apply to the Board for a declaratory statement as described in Part D of this article. As with RESPA, Investing Physicians can argue that if they make similar disclosures, then they should be able to receive a return on their investment in the Owning Entity.

D. Declaratory Statement • Investing Physicians also can submit a plan to invest in a Facility to the Board of Medical Examiners for its review. The Board follows the procedure described in Rule 28-4 of the *Florida Administrative Code*.[26] Rule 28-4 states that any person may seek a declaratory statement with respect to the applicability of a specific statutory provision or of any rule or order of the agency, i.e., the Board, as it applies to the petitioner in its particular set of circumstances only. Rule 28-4 then sets forth the requirements for an application for a declaratory statement.

The application must include the name of the petitioner, the address of the petitioner, the name of the agency, the agency rule, order, or statutory provision on which the declaratory statement is sought and a description of how the rule, order or statute may or does affect the petitioner in his particular set of circumstances. The petitioner must also sign the declaratory statement.

E. Proposal to revise existing law • The Florida legislature should act promptly to remove the ambiguity in the present law. In this respect, the legislature can look for guidance from a recent California statute.[27] The California statute requires an Investing Physician or his immediate family to first disclose to the patient that he or his family has a significant beneficial interest in a certain Facility and that there are alternative Facilities available. The statute defines "significant beneficial interest" as 5% of the Facility or $25,000. In California, an Investing Physician complying with these requirements can legally receive a return on investment in a Facility.

F. Conclusion • Until the Florida legislature amends existing law applicable to physicians' referrals of their patients to Facilities in which they have a financial interest, the legality of such referrals is in limbo. The guidelines suggested in this article should help protect an Investing Physician from a charge of impropriety. Because the structure of the business arrangement of each facility is different, however, any physician contemplating investing in a Facility to which the physician shall refer patients should consult legal counsel.

References

1. FLA. STAT. Section 458.331 (1985).
2. Outdated Kickback Law Leaves Doctors in Limbo, South Florida Medical Review, June 4, 1985, at p. 3.
3. Under FLA. STAT. Section 458.331(2)(b) (1985), the Board of Medical Examiners is empowered to revoke or suspend the license of any person found to have violated the provisions of Section 458.331(1), which include the anti-kickback provision at issue here.
4. Wallis, How to Beat Hospital Costs, Time, Sept. 5, 1983, p. 52.
5. Schiffres, Behind the Surge of Walk-in Medical Clinics, U.S. News & World Report, Dec. 6, 1983, p. 75.
6. South Florida Medical Review, supra, at 3.
7. Friedman, Emergency, Inc., Aug. '85, p. 48, at 50.
8. FLA. STAT. Section 458.331 (1985).
9. 348 S. 2d 923 (Fla 1st DCA 1977).
10. See footnote 3 supra
11. FLA. STAT. Section 458.1201(m) (1977) (repealed 1981).
12. 348 S. 2d at 926.
13. FLA. STAT. Section 458.331(1)(j) (1985).
14. FLA. STAT. Section 458.331(1)(o) (1985).
15. 465 So. 2d 1324 (Fla 1st DCA 1985).

16. Id. at 1324-25.
17. Id. at 1325 n.2.
18. 42 U.S.C.A. Section 1395 nn(b)(1), Section 1396 (h)(b)(2).
19. Id.
20. 604 F.2d 999 (7th Cir. 1978).
21. Id. at 1002.
22. See, e.g., United States v. Tarpert, 625 F.2d 111 (6th Cir. 1980) ("We agree with the definition of 'kickbacks' adopted and applied by the Seventh Circuit"); Contra, United States v. Porter, 591 F.2d 1048 (5th Cir. 1979) ("In ordinary parlance a kickback is the return to an earlier possessor of part of a sum received." at 1054).
23. Webster's New World Dictionary, (The World Publishing Company 1970).
24. 12 U.S.C.A. Section 2601 et. seq
25. Id. at Section 2607
26. Rule 28-4.01 et. seq. Florida Administrative Code (1974)
27. CAL. STAT. Section 654.2 (1985).

Acknowledgment

The authors thank Paul Dwyer for his research assistance.

- Mr. Register, 3300 Henderson Blvd., Suite 200, Tampa 33609.



MediMac™

Because the business of medicine is as important as the practice of medicine.

The more efficiently you manage the business end of your practice, the more time and energy you have for patient care. Fortunately, the easiest way to put your business in order is also the best... MediMac.

- An incredibly easy-to-use system utilizing all the power of the amazing Macintosh™ from Apple Computer.
- Provides complete billing and insurance processing, recordkeeping and practice management.
- Integrates with other quality programs such as Microsoft Word™, File™ and Excel™ to give you powerful word processing, database and graphics capabilities.
- Can be mastered in hours, not days or weeks.
- All these features and more provide increased productivity and efficiency... and save you money in the process.

For more information call Kathleen...

1-800-422-6227

MediMac...the easy way to efficient practice management.

HealthCare Communications ■ 245 South 84th Street – Suite 301 ■ Lincoln, NE 68510

Macintosh is a trademark licensed to Apple Computer Inc.
MediMac is a trademark of HealthCare Communications
Word, File and Excel are trademarks of Microsoft Corporation

QUESTION:

What do hundreds of physicians throughout the Southeast have in common?

ANSWER:

Their clinics are supported by ISI's Medical Management Software on IBM Computers.

THE MEDICAL SYSTEM INCLUDES:
- Paperless claims in Florida
- Patient Statements & collection letters
- Third party billing
- Financial Practice Analysis
- Procedure Diagnosis Analysis
- Online Appointment Scheduling
- Hospital Census
- Time Payments

AND MUCH MORE!

ADVANTAGES
- Designed to operate on the IBM System/36 Computer
- Quick Return on Investment
- Installation and Training provided
- Ongoing support available
- Custom modifications available

INTERESTED?
For more information Call or Write
Director of Marketing
Info Systems of N.C., Inc.
P.O. Box 18466
Charlotte, NC 28218
(704) 535-7180

The ISI Software Question

Managing your practice so you can practice your profession.

INFO SYSTEMS of N.C. Inc.

This space contributed as a public service.

YOU CAN FIGHT CANCER BEFORE YOU GET IT.

OR AFTER YOU GET IT.

It's a lot easier to fight cancer before you get it.

Scientists estimate that up to 60% of all cancer could be prevented.

By simply making a few changes in your lifestyle.

By not getting too much sun. By not smoking cigarettes. By not overeating. And by following a diet high in fiber and low in fat.

By simply doing these few things, you could drastically reduce your risk of getting cancer.

Sure, you could still get cancer.

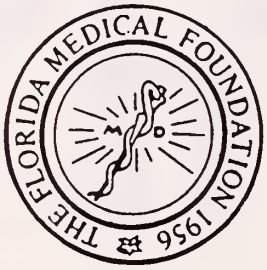
But why not give yourself the odds against it?



Help us keep winning.

Physicians' Confidential Assistance





Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 709
- ☐ DEAN'S MESSAGE, 710
- ☐ ENCORES!, 711

☐ NOTES & NEWS

Joint commission emphasizes education, technical assistance in new division

The Joint Commission on Accreditation of Hospitals has established a new Division of Education to further its educational and technical assistance outreach to health care practitioners and providers. The new Division incorporates the existing Department of Publications, expands the functions of the Department of Education Programs, and establishes a new Department of Educational Resources.

"The Division of Education is responsible for the educational products, programs, and services of the Joint Commission. The strengthening of these activities is a high priority," said newly appointed Vice President for Education William F. Jessee, M.D. "The Division will add new momentum to our education and technical assistance efforts."

Emphasis will focus on:

- Offering educational programs and products designed to address specific problems encountered by health care facilities and systems complying with standards.
- Expanding the range of educational materials offered to assist facilities and systems in meeting standards, including the development of software to support quality assurance and risk management data systems.
- Developing educational initiatives in risk management; and,
- Developing an expanded capacity for on-site technical assistance implementation of a program to offer problem-focused consultation to facilities experiencing specific problems in meeting accreditation standards.

The organization and function of each new department is summarized below.

Department of Education Programs: This department develops, manages, and evaluates educational programs designed to help health care facilities and systems meet accreditation requirements. This department also plans and conducts in-service education for Joint Commission surveyors.

Department of Publications: This department develops, edits, and produces publications and other educational products designed to assist health care organizations in understanding and complying with standards. This department publishes all accreditation manuals and special publications related to the Joint Commission and voluntary accreditation. The department also publishes all Joint Commission periodicals such as the *Quality Review Bulletin*, a refereed monthly journal, *JCAH Perspectives*, a bi-monthly newsletter, and the *Plant, Technology, and Safety Management (PTSM) Series.*

Department of Educational Resources: This department is responsible for idenifying and managing the provision of resources to support education programs and publications. In addition, the department will manage development of a new program of consultative technical assistance to facilities and systems and provides support for ordering and distribution of publications, products, and programs. The managment of educational assistance material for the library and resource is also handled here.

"The scope and quality of programs, products, and services offered to health care organizations is being substantially increased through the use of this structure. In addition, the new division enhances our ability to provide specific consultative technical services to health care facilities seeking to improve their internal quality assurance activities," Dr. Jessee noted. "Finally, expnaded and enhanced surveyor education programs should improve the quality and consistency of the survey process."

"Education is a critical function of the Joint Commission," said Joint Commission President Dennis S. O'Leary, M.D.. "The establishment of the new Division emphasizes the importance of education in the scope of Joint Commission services. I strongly support the new Division in expanding this important area of service to health care organizations.

Hospital admissions still declining

Growing incentives for cost effectiveness, increased competition and, in some regions, recessionary impacts of local economic problems, pushed hospital admissions nationwide 4.6% lower in 1985 than in the previous year, according to *Economic Trends 1985 Year in Review*, just released by the Hospital Research and Educational Trust.

"Although total admissions were down sharply in 1985 relative to a year earlier," the reports says, "more recent quarterly data suggest a slowing of admission declines at the national level and in most regions and bed-size groups." But the report goes on to say that this slowing may only be temporary as the strong growth in ambulatory-care technology and public acceptance continues and more and more people enroll in HMOs and preferred provider organizations.

The biggest decline in hospital admissions was seen in the 65-and-older population, which had 5% fewer admissions than in 1984. And admissions decline tended to be steepest for small, rural and nonteaching hospitals. Reflective of the decline in admissions, outpatient visits rose 4.8%, or by nearly 11 million, compared to an increase of only 1.1% in 1984.

Lengths of stay, however, dropped by only 1.1% in 1985, slowing the rapid rate of decline experienced in 1984, which came in response to changing financial incentives — such as prospective pricing — to keep patients in the hospital. According to the report, length-of-stay reductions were less drastic in 1985 because a higher percentage of inpatients suffered from more severe illness, while less-severely ill patients were steered away from inpatient treatment.

Shorter hospital stays and fewer admissions led many hospitals to reduce staffing and beds, the report says. But, while hospitals nationwide cut back on full-time employees, the number of part-time employees increased, allowing hospitals more flexible staffing to better accommodate volume shifts.

While shorter stays, more moderate inflation, declining admissions and staff and bed reductions worked to slow the growth of hospital expenses, increases in malpractice and other insurance premiums, a continued growth in drug prices and the growing use of consulting and marketing services pushed total expenses higher last year. Aggregate hospital expenses, on a national level, increased to a rate of 6.6%, up from 4.6% in 1984.

The increase in expenses and competitive pressures to keep prices down, along with the overall decrease in hospital admissions and lengths of stay, hampered revenue growth. Total net revenue margins nationally fell to 5.9% from 1984's 6.2%, says the report.

Economic Trends a quarterly report on national hospital finances, utilization and staffing trends, is produced jointly by the Hospital Research and Educational Trust and the American Hospital Association's Office on Public Policy Analysis. Subscriptions to *Economic Trends* ($45.00 per year) are available from The Hospital Research and Educational Trust, 840 N. Lake Shore Drive, Chicago, Illinois 60611, 1-800-AHA-2626. Please request item M45.

Founded in 1944, the Hospital Research and Educational Trust (Trust), an affiliate of the American Hospital Association serves local communities by helping to provide high-quality, affordable health care services through research, demonstration, publishing and educational activities.

DEAN'S MESSAGE

The declining interest in medicine: a major concern

The applicant pool for positions in United States medical schools has declined 22.8% since 1974 and is projected to continue to decline.

For over 40 years, medicine proved to be an attractive career option for young people. In the years following World War II, spurred by a bolus of World War II veterans, the ratio of applicants to acceptees was 3.5 to 1. This ratio dropped in the '50s and '60s to a stabilized ratio of 1.9 to 1. With an expanding population and an expanding number of medical schools, the number of applicants rose to a ratio of 2.8 to 1. Since 1974, the number of applicants has continually declined from 42,624 to 32,893 for 17,228 positions. The current ratio is 1.9 to 1.

The decline has not been uniform. For example:

1. The number of undergraduate minority applicants has decreased at a slower rate.
2. The number of female applicants is declining, but now females constitute 35.1% of the total pool.
3. Applicants in 1985 were more likely to have significant debts.
4. Applicants in 1985 were less likely to come from small, liberal arts colleges.
5. The career interest of applicants is changing also:
 - A. Interest in family practice has declined from 40% to under 24% in the past five years.
 - B. Those interested in surgery or surgery subspecialties are on the rise 18% to 28% in the past five years.

 Note: The quality of the applicants remain stable.
6. In selected states, the declines have been dramatic. In one year (1984-1985), the following states have had a decrease in applicants of more than 20%: Oregon, Maine, Minnesota, New Hampshire, West Virginia, Georgia, Hawaii.

Florida decreased 3.6% and 12% in the past five years.

Parenthetically, let me be quite clear, this is not a self-serving message. The University of Florida College of Medicine applicant pool is very stable at

1,800 for 85 positions, because of the high quality of education and an extremely favorable tuition ($3,200 per year).

Therefore, the problem is a national problem, not an Alachua County problem. Again, I want it to be clear in your minds that this is not a self-serving message.

The projected number of applicants is expected to decline further. One might say that is because the number of 22-year-olds is decreasing. However, the percentage of college freshmen expressing interest in a career in medicine has been increasing in recent years! In fact, one could predict that a 15% increase in applicants would have occurred in the past five years — instead a 10.4% decrease occurred!

These data suggest that the decline in medical school applicants observed in recent years is not due to a declining population base nor to a decline in early career interests in medicine, but possibly to a growing disaffection with medicine during college.

Let's examine some of the possible reasons for this disaffection:

1. The GMENAC Report of 1981 predicted a huge surplus of physicians in the United States by 1990. Perhaps young people want to be assured of a future job.
2. There is a perception and the reality is here that the financial rewards of a medical career will not be as great as in the past. To young people who enter medicine for financial rewards purely — we do not want them anyway.
3. The amount of time required to become qualified to practice is a minimum of seven years. Some young people today are oriented to instant rewards and not willing to invest in a career that requires a long training program.
4. The indebtedness incurred by medical students today is rising. Eighty-seven percent of graduating seniors have debts; these debts average $29,943!
5. Therefore, the cost/benefit ratio, considering lost earning from the long years of training, coupled with increased educational costs, may not be perceived as favorable.
6. The malpractice insurance crisis, which is receiving so much attention in the press, may be scaring young people away from the profession.
7. The alternative modes of health care delivery impress young people that medicine is under siege from without and, therefore, not an attractive career option. In fact, 40% of the 1985 graduates expect to work in a salaried capacity. This was 30% five years earlier.
8. Finally, there is a pessimistic view of the future of medicine among established practitioners. Many career interests in medicine are kindled by a personal relationship with physicians. Harrison Rogers, M.D., President of the American Medical Association, in December 1985 said: "It is the change I begin to see taking place in the attitude of physicians toward the future of their profession and toward their choice of profession. . . the changed attitude of those who say they would advise their sons and daughters not to become doctors. It is the one change I see that genuinely concerns me."

If we do not continually attract our own young people to consider medicine as a career choice — we are in fact surrendering to all the external forces that have affected the sweeping changes in medicine and we are committing professional genocide!

Other health professionals will continue their advances on the practice of medicine.

Finally, I submit that medicine is still an honored profession and a privileged profession. The doctor-patient relationship is almost sacred in human behavior. The intangible rewards of treating the sick are incalculable.

May I suggest to the Alachua County Medical Society that this society initiate mini-internships for college students interested in medicine, in order for these young people — the brightest and the best — to see first-hand, alongside a respected member of the profession, what medicine really is all about. The program would become a state and national model.

We as a profession must assure that the people of this nation have their health care rendered by bright, dedicated, enthusiastic practitioners of the art and science of medicine. We cannot afford to disaffect talented young people from a career in medicine because of external and, hopefully, transient conditions.

William B. Deal, M.D.
Dean and Associate Vice President
for Clinical Affairs
University of Florida
College of Medicine
Gainesville

Presented by Dr. Deal to the Alachua County Medical Society, April 8, 1986.

ENCORES!

O-Ring syndrome

I have lots of friends who are pure bureaucrats, at least in their professional lives. I suppose most of them are charming; and understand that I have nothing special against "Bureaucracy" as a professional calling. I try to forgive them all their plans and edicts directed one way or another at my own

individual self, just as I hope they forgive me when I stick a needle in them for some surgical purpose or other.

So, appearances to the contrary, do not read this as a too bitter indictment of the administrative process. But after all, since I feel my own professional doings are under such microscopic scrutiny by the bureaucratic gaze, and that I am (as T.S. Eliot put it) quite "formulated, sprawling on a pin," I beg allowance to myself the pleasure of spitting back at them some "butt-end of my ways."

As for O-Rings, and the Challenger's loss, my own court of inquiry has decided to lay the responsibility for that accident directly upon the due process of Bureaucracy, I suppose I want to point out, and hope, that the archetypal Bureaucrat will learn a lesson from this disaster, but in the long run I doubt it. Individuals may be chastened, but the process has a life of its own, and new faces replace the old.

But let me interpret facts, as presented in the most recent issue of *The Scientific American*, regarding the faulty O-Rings. In the pictures reproduced of space shuttle launches, even I could clearly see black smoke emanating from the O-Ring vicinity. The smoke as shown was not pale and vapid, but black and wicked; it is a smoke which, if not quite fire, seemed strikingly worthy of acknowledgement and even investigation. The engineers, who knew their business, saw it; but not so, even when pointed out to them, the Bureaucratic eye, which appears trained to gaze on more distant and ideal horizons uncluttered by contradictory detail. Aside from which engineers, whose business it is to know something about smoke (as equally, perhaps, teachers about teaching, doctors about doctoring, etc.) are in a curiously anomalous position in that though they make the thing fly, they are mere outsiders to the Bureaucratic establishment's perhaps more basic goals of funding, expansion, and self-imaging.

The Challenger tragedy, and the responsibility for it, appears traceable to the ancient bugbears of hubris and pride; Bureaucratic conceit and delusions of grandeur, self-importance, omniscience, and omnicompetence; not to leave out, by all means, the insidiously insistent need of such institutions towards self-aggrandizements ultimately impossible to sustain. It is true that any profession, including ours, may be tempted into such conceit; but Bureaucracy seems to do so almost as policy.

In the case of the space shuttle, policy took clear precedence over professional judgement and experience. The policy-makers were shown O-Rings burnt one-third the way through; and from that drew the lethal conclusion that two-thirds of an O-Ring demonstrated a 66% safety margin. Alas!

As for the symptoms of O-Ring Syndrome they are multitudinous, but at least the following triad is a start in diagnosis:

1. A certitude that high-falutin' words somehow make for successful deeds.
2. The success of an endeavor is less related to common experience than to the amount of paper it takes to describe and regulate it, and funds to fund it.
3. The general and statistical points of view always supersede the individual and subjective.

In as diffuse an undertaking as the restructuring of health care and its "delivery," it is hard to know what "O-Rings" reside in the depths of that shiny package; and hard to discover the smoke in the fog of legislation surrounding so broad an issue. But as physicians our responsibilities, unlike the NASA engineers, are not entirely superseded by Bureaucratic fiat. We are still, after all, treating the individual patient and remain, I think, competent guardians of that trust.

Charles E. Moore, M.D.
Tallahassee

Reprinted with permission from *Cap Scan*, the newsletter of the Capital Medical Society, September 1986.

The tragedy of Ham Let heir of Hippocrates

From Act III. Scene I.

Enter: Ham Let, M.D., P.A.

To HMO, or not to HMO: that is the question.
Whether 'tis nobler in the mind to suffer
The slings and arrows of outrageous competition,
Or to take arms against a sea of prepaid plans,
And by opposing end them. To practice; to care;
No more; and by participating to say we end
The rewards and the thousand natural joys
That private practice is heir to. 'Tis a consummation
Devoutly to be wish'd by many a entrepreneur.
To practice; to care; — To care? Perchance to control!
Ay, there's the rub; for in losing control
Over our patients' care what result may come,
When their advocate has shuffl'd off his mortal soul,
Must give us pause. There's the aspect
That makes calamity of treatable illness.
For who would bear the whips and scorns of society,
The government's wrong, the businessman's bottom line
The pangs of rejected claims, the law of torts,
The insolence of elected office, and the spurns
That the ungrateful utilizer takes,
When he himself might seek acquittance
By early retirement? Who would such burdens bear,

To grunt and sweat through medical training,
But that the dread of something after that,
The values from whose boundary
No physician returns, puzzles us still
And makes us rather bear those DRGs we have
Than fly to others that we know not of?
Thus conscience does make cowards of us all;
And thus the native hue of utilization
Is sicklied o'er with the pale cast of cost containment
And enterprises of great pith and moment
With this regard their benefits turn awry
And flee from professional ideals. —

Soft you now! Unfair O. Phelia, nurse in thy PRO
Be all my profiles rememb'red.

Karl M. Altenburger, M.D., P.A.
Ocala
(To W.S. — with apologies)

Reprinted with permission from *The Bulletin of Marion County Medical Society,* March 1986, Vol. 8, No. 3.

Ten Commandments for proper prescribing

(From the Committee on Drug and Alcohol Abuse, Medical Society of New Jersey)

1. Never prescribe without properly recorded history and physical examination.

2. Be suspicious when the patient suggests what to prescribe.

3. Telephone prescriptions should only be given to known patients for well-established reasons in small amounts. A written prescription must follow within 24 hours.

4. Refill only at office visits or for exceptional other reasons.

5. Be suspicious of "lost" or "spilled" excuses for extra prescriptions. (These are common excuses to supply friends and family members with these substances.)

6. Confront repeated suspicious requests or uses directly. (Your license and reputation are at stake.)

7. Be careful to prevent theft of prescription pads. (Employees should not have free access to prescription pads.)

8. Be very wary of manipulative patients who may attempt to obtain drugs in order to redirect their distribution.

9. Do not have DEA number printed on prescription blanks.

10. Do not prescribe controlled substances for family members, colleagues, or employees without appropriate and recorded history and physical examination.

Reprinted with permission from the *Membership Newsletter* of the Medical Society of New Jersey, Vol. 34.

"Deafness is something you put beside you not in front of you."

LINDA BOVE / ACTRESS



PHOTO HELEN NESTOR

Linda Bove performed with The National Theatre of the Deaf for nine years. She has also starred in the Tony Award winning show, *Children of a Lesser God*.

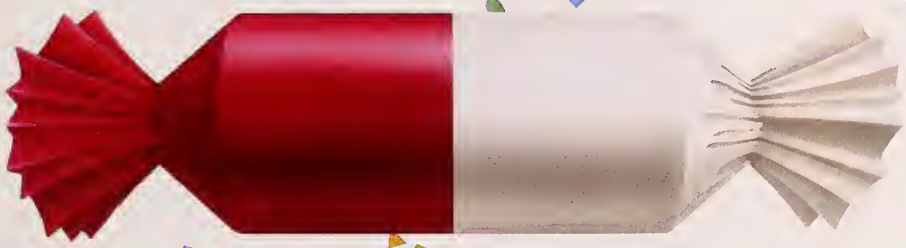
Believe in them. Break the barriers.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, WASHINGTON D.C. 20210

PRODUCED BY THE SCHOOL OF VISUAL ARTS PRESS, LTD

10 YEARS

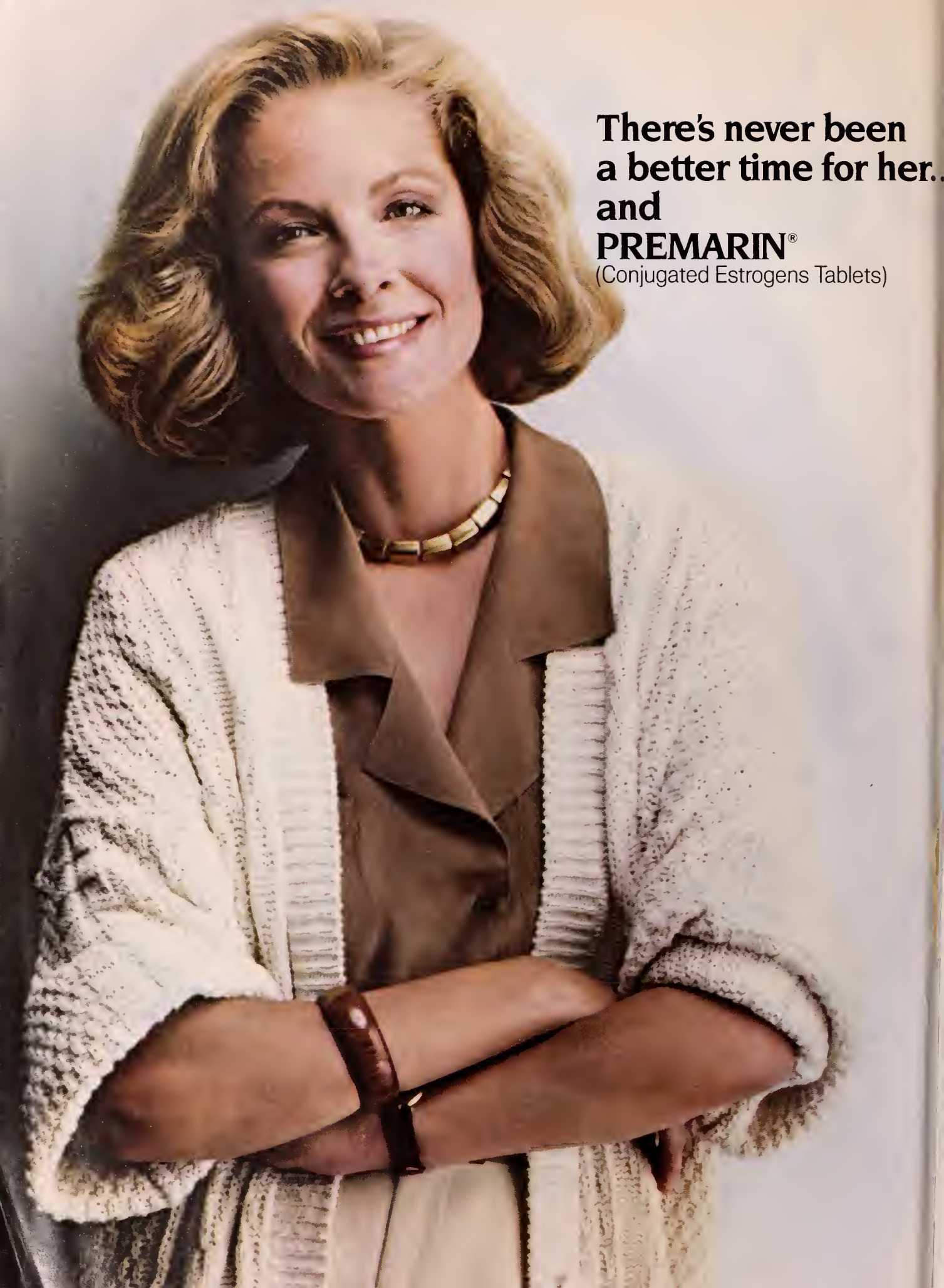
Thank you for your loyal support



DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

SK&F CO.



There's never been a better time for her.. and PREMARIN®
(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®
(Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

The appearance of these tablets is a trademark of Ayerst Laboratories.

For atrophic vaginitis

PREMARIN®
(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy. (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985; 67: 496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1:41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

© 1986 Ayerst Laboratories

Ayerst® AYERST LABORATORIES
New York, NY 10017

T6194/886

Pensacola: Spaniards to space age

By Virginia Parks, 128 pages. Price $11.95. Pensacola Historical Society, Pensacola, 1986.

For a pleasant and informative day's reading I commend the above small volume to your attention. The subject is the biography of the first West Florida city, indeed the first European settlement of the North American continent. Initially settled August 14, 1559, in response to a Royal Cedula of King Phillip II of Spain, Pensacola has had a tortuous life. Within a few months of its settlement it was abandoned for a century and a quarter then resettled by the Spanish. Then came capture by the French, repossession by the Spanish, secession to the British, return to the Spanish and finally purchase by the United States. Few cities can claim such kaleidoscopical legacy.

In this little volume the social life, business life and military life of Pensacola is portrayed at each turn of the city's fortunes. The vehicles of these portrayals include appropriately chosen quotations of contemporaries, human interest stories and delineations of important personalities. The many black and white line drawings, maps and photograph reproductions are well crafted and supplement the text. While not intended as a scholarly resource for advanced students of Florida history, quotations and significant statements of fact are documented at the end of the text.

In a paragraph, the author, Virginia Parks, the editor of Pensacola Historical Society publications, guides you through the maze of changing Pensacola fortunes with a skillful pen that never fails to hold your interest.

William M. Straight, M.D.
Coral Gables

- Dr. Straight practices internal medicine in Coral Gables. He is the former historical editor of *The Journal of the Florida Medical Association.*



Her brother had Duchenne Muscular Dystrophy. Which means that though she herself is unaffected by the disease, she could be *carrying* it in her genes.

And if she is, there's a one-in-four chance her child will inherit Duchenne.

One of the most common and devastating forms of muscular dystrophy, Duchenne is usually passed from mother to child by a defective gene. The task of MDA researchers is to find that gene. And right now they're so close that MDA is pouring all possible resources into the quest.

Once the gene for Duchenne is identified, carriers can be identified, too —with 100% certainty. And the first major step toward finding a cure will have been taken.

MDA

Muscular Dystrophy Association, Jerry Lewis, National Chairman

Auxilians cared in 1986

"We Care," the Florida Medical Association Auxiliary's theme for 1985-86, was exhibited enthusiastically by county auxiliaries across the Sunshine State. Auxilians cared about Child Abuse Prevention, Missing Children, Drug Abuse, Cancer Screening, Infant Automobile Restraints, Seat Belt Safety, Spouse Abuse, Birth Defects, Organ Donor programs, Drunk Driving, Stress, C.P.R. courses, Health Fairs and a number of other programs.

Senior citizens in Florida benefited by over 40 programs and projects carried out by Auxilians. These projects included Hospice involvement, working in Day Care Centers for the Elderly, nursing home visitations, educational programs, equipment loans, and transportation services. The Medifile cards were distributed in Spanish as well as English.

Florida Auxilians were extremely active in fund raising activities. Auxilians raised $101,365.92 for the American Medical Association-Education Research Foundation. International Health activities raised $6,500 for Interplast South. Almost $100,000 was raised for scholarships and student loans.

Legislation was of high priority this year. Legislative seminars were held in the ten most populous counties with C.M.E. credits for physicians in attendance. The Auxiliary supported "The Day in the Right Direction" in full force. The new mid-May format for the annual "Days in the Capitol" was a huge success. Auxilians were very successful with their lobbying efforts for tort reform and other issues.

The Missing Children Poster Program produced outstanding participation and cooperation with the media around the entire state. The program was mentioned in over 50 television, radio or newspaper articles. The participation by the physicians in Florida was greatly appreciated.

The major health issue focus for the Auxiliary this year was Child Abuse Prevention. The Auxiliary cosponsored the Conference in Jacksonville for Child Protection Teams in Florida and the Child Abuse and Neglect Prevention Task Force. A special seminar was held at the Fall Conference on the subject of Child Abuse Prevention. Almost every County Auxiliary in Florida conducted a program and/or project this year on Child Abuse Prevention.

This brief summary of the year's programs gives a mere glimpse into the activities of the Auxiliary's involvement in their communities around the state. As in any organization, its strength is in its membership. I would urge all physicians in Florida to encourage their spouses to join the Florida Medical Association Auxiliary.

This has been a very productive and rewarding year for the Florida Auxiliary. I am most grateful for the opportunity to have served as its President.

Mrs. Milton R. (Jo) Tignor
President, FMA Auxiliary
North Palm Beach

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special programs at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

a division of Subscription Services, Inc.

29 Glen Cove Avenue • Glen Cove, New York 11542 • 516-676-4300

Our members qualify for low professional subscription rates for magazines for office reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION	(No. of issues per yr.)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE
American Health	10	14.95	12.95	11.95
American Heritage	6	24.00	18.00	18.00
Amer.Photog.[Special:	9 iss.]	7.47		7.47
Americana	6	11.95	11.95	9.95
ArtNews	12	29.95	25.95	25.95
Atlantic Monthly	12	9.95	9.95	9.95
Audio	12	17.94	8.97	8.97
AUTOMOBILE	12	24.00	12.00	
	2 yrs		22.00	
Baseball Digest	12	14.95	14.95	
for Educators:	10 issues			7.97
Basketball Digest	8	9.95	9.95	7.97
#Better Homes&Gdns	12	14.00	7.00	14.00
#BICYCLING	10	15.97	8.00	12.97
Black Enterprise	12	15.00	15.00	11.95
Boating	12	19.98	16.97	16.97
Bon Appetit	12	15.00	15.00	15.00
Boys Life	12	13.20	13.20	13.20
Car & Driver	12	16.98	11.99	11.99
Changing Times	12	15.00	9.97	9.97
#Connoisseur	12	19.95	10.00	19.95
Consumers Reports	12	16.00	16.00	16.00
#Cosmopolitan	12	24.97	15.00	24.97
Cruising World	12	18.00	18.00	14.00
Cycle	12	13.98	6.99	6.99
Cycle World	12	13.94	7.97	7.97
DISCOVER	12	23.95	13.00	14.95
Downbeat	12	18.00	18.00	9.95
EBONY	12	16.00	9.97	9.97
The Economist	52	85.00	51.00	51.00
#ELLE	12	24.00	16.00	
EM (Ebony Man)	12	24.00	19.95	19.95
ESQUIRE	12	17.94	9.95	9.95
Essence	12	12.00	9.96	9.00
Family Circle	17	14.97	9.97	
Family Computing	12	19.97	11.97	11.97
Family Handyman	10	9.95	9.95	5.95
Field & Stream	12	15.94	8.97	8.97
Fifty Plus	12	15.00	11.97	11.97
Financial World	26	41.95	24.94	
FLORIDA TREND	13	24.00	24.00	
Flying	12	18.98	15.97	15.97
Food and Wine	12	18.00	9.00	15.00
Football Digest	10	12.95	12.95	7.97
Forbes	28	42.00	42.00	28.00
Fortune	26	44.00	35.30	22.25
Games Magazine	12	15.97	15.97	15.97
Gentlemens Quartly	12	18.00	13.50	
Glamour	12	15.00	12.00	
Golf Digest	12	19.94	11.98	11.98
Golf Illus.[Special:	8 issues]	5.97		5.97
Golf Magazine	12	15.94	9.97	9.97
#Good Housekeeping	12	15.97	9.97	15.97
Gourmet	12	18.00	13.50	15.00

PUBLICATION	(No. of issues per yr.)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE
#Harpers Bazaar	12	16.97	8.97	16.97
Harpers Magazine	12	18.00	9.97	9.97
Health [Special:	9 issues]		9.97	9.97
High Fidelity	12	13.95	6.98	6.98
Home Mechanix	12	11.94	8.97	8.97
The Homeowner[Special:	6 iss]		8.97	8.97
Home Viewer	12	18.00	11.97	11.97
Hot Rod	12	13.94	8.97	8.97
House and Garden	12	24.00	18.00	
#House Beautiful	12	15.97	7.99	15.97
Humpty Dumpty (4-7)	8	11.95	9.97	9.97
Inc.	12	24.00	12.00	12.00
Jerusalem Post	24	18.46	18.46	15.97
Jet	52	36.00	26.00	26.00
Ladies Home Journl	12	20.00	13.32	10.00
LIFE	12	32.50	16.25	
M (Civilized Man)	12	24.00	19.95	
Mademoiselle	12	15.00	12.00	
McCall's	12	11.95	7.95	
Metropolitan Home	12	18.00	18.00	9.00
Modern Photography	12	13.98	7.98	6.99
MONEY	12	29.95	15.00	
Mother Jones	12	24.00	16.00	16.00
Motor Trend	12	13.94	7.97	7.97
MS Magazine	12	16.00	10.97	10.97
The Nation	52	28.00	28.00	
for Educators:	24 issues			9.95
Nation's Business	12	22.00	12.97	12.97
Natural History	12	20.00	20.00	
N.E.Journal of Med.	52		60.00	
New Republic	52	48.00	48.00	28.00
N.Y. Rev of Books	17	28.00	28.00	25.95
New Woman	12	15.00	9.95	11.97
New Yorker	52	32.00	32.00	20.00
NEW SHELTER,new name:	PRACTICAL HOMEOWNER			
#NEWSWEEK	52	41.00	20.80	21.85
Omni	12	24.00	15.96	15.96
1001 Home Ideas[Spec'l:	8 iss]	11.97		11.97
Organic Gardening	12	12.97	9.97	9.97
Outdoor Life	12	13.94	7.97	7.97
Outside	10	16.00	12.00	8.97
Ovation	12	18.00	10.00	10.00
PARENTS	12	18.00	9.00	
Penthouse	12	36.00	30.00	30.00
People	52	56.00	56.00	28.25
Personal Computing	12	18.00	18.00	11.97
Petersens Photgrph	12	13.94	6.97	6.97
Playboy	12	25.00	21.50	21.50
#Popular Mechanics	12	13.97	7.00	13.97
Popular Photogrphy	12	11.97	5.99	5.99
Popular Science	12	13.94	7.97	7.97
#PRACT'L HOMEOWNER	9	10.97	5.50	9.97
#PREVENTION	12	13.97	7.00	13.97

PUBLICATION	(No. of issues per yr.)	REG. SUBSCR PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE
PSYCHOLOGY TODAY	12	15.99	8.00	12.97
Reader's Digest	12	15.41	15.41	15.41
#Redbook	12	11.97	6.97	11.97
Road and Track	12	17.94	12.99	12.99
Robb Report	12	65.00	65.00	
The Runner [Special:	8 iss.]	8.97		8.97
#RUNNER'S WORLD	12	19.95	10.00	12.97
Sail	12	21.75	21.75	21.75
Saturday Eve. Post	9	12.97	12.97	12.97
Savvy [Special:	9 issues]		8.97	8.97
#Science Digest	12	13.97	6.99	13.97
Scientific Amer'n	12	24.00	24.00	24.00
Self	12	15.00	12.00	
Seventeen	12	13.95	13.95	13.95
Ski	8	11.94	6.97	6.97
Skiing	7	9.98	5.97	5.97
Skin Diver	12	13.94	7.97	7.97
SOUTHERN ACCENTS	12	18.00	16.00	
SPORT	12	12.00	7.97	7.97
Sporting News 24:6	mo	22.50	11.97	11.97
#Sports Afield	12	13.97	6.99	13.97
SPORTS ILLUSTRATED	54	58.80	34.00	29.45
Stereo Review	12	9.98	4.99	4.99
S.Porters Pers.Fin.	12	19.97	19.97	
Teen	12	12.95	7.95	7.95
Tennis	12	17.94	8.97	8.97
TIME	52	58.25	29.25	
#Town & Country	12	24.00	12.00	24.00
Travel & Leisure	12	25.00	12.50	25.00
TV Guide	52	31.20	31.20	26.00
UNIQUE HOMES	6	30.00	24.97	24.97
USA Today	260	92.00	92.00	78.00
U.S.News&World Rep	52	34.50	34.50	17.25
US Magazine	26	23.95	12.95	12.95
	2 yrs.	23.95		23.95
Vegetarian Times	12	19.95	14.95	14.95
Video	13	12.00	8.97	8.97
Video Review	12	12.00	6.97	6.97
Village Voice	52	32.76	32.76	16.50
Vogue	12	24.00	21.00	
W Magazine	26	26.00	23.00	17.95
Weight Watchers	12	13.97	11.97	11.97
Woman's Day	17	15.13	15.13	15.13
Women's Sports	12	12.95	7.97	8.95
WORKING MOTHER	12	11.95	7.95	
Working Woman	12	18.00	12.00	15.00
World Press Review	12	16.95	16.95	14.98
World Tennis[Special:	6 issues]	5.97		5.97
WORLD TRAVELING	4	11.00	9.95	9.95
Writer's Digest [Spec:	9 iss.]	9.97		9.97
Yachting	12	19.98	16.97	16.97
Yankee (Colonial)	12	18.00	18.00	14.95
YM (Young Miss)	12	14.00	10.95	10.95

BUSINESS CARD NEEDED FOR OFFICE PRICE

FMA MAGAZINE PROGRAM
29 Glen Cove Avenue
Glen Cove, New York 11542

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Complete for Educator rates:

_____ _____
Name of Educator Affiliated Hospital / School

☐ VISA
☐ M/C No. _____ Exp. Date _____

You may pay by check or credit card. Please make checks payable to FMA Magazine Program.

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

Terms: Subscriptions are one year unless otherwise noted. Prices subject to publishers' changes.
Guarantee: Our prices are the lowest, our service the best.
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date
New Orders: Publishers take from 8 to 12 weeks to start your subscription.

FLM0786

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

SEPTEMBER

Breaking the News, September 9, 1986, Doctors Hospital of Lake Worth, Lake Worth. Contact: Roberto Miguel, M.D., 2889 10th Avenue North, No. 203, Lake Worth, 33461, (305) 965-3280.

Doppler Echocardiography Seminar, September 11-13, Innisbrook Resort, Tarpon Springs. Contact: Ann Connelly, R.N., 300 South Hawthorne Road, Winston-Salem, NC 27103.

Problems of Adolescence-Eating Disorders, September 12, 1986, West Florida Reg. Medical Center, Pensacola. Contact: Phyllis Connerly, 8383 N. Davis Highway, Pensacola, 32504, (904) 4787-4460, Ext. 4178.

Regional Scientific CME Meeting, September 12-14, 1986, Contemporary Hotel, Orlando. For more info: Eugene Schiff, M.D., VA Medical Center, 1201 N.W. 16th Street (D-1011), Miami, 33125, (305)324-3172.

Legal and Ethical Dilemmas of Health Care, Sept. 18-19, Fla. State Conference Center, Tallahassee. For more information: I.B. Harrison, M.D., (904) 681-5121.

Aviation Medical Seminar — For Aviation Medical Examiners, September 18-21, Doral Hotel, Miami. Contact: James L. Harris, M.Ed., P.O. Box 25082, Oklahoma City, OK 73125, (405) 686-4881.

Pharmacologic Management of the Elderly Patient, September 18-19, 1986, Gainesville Hilton, Gainesville. Contact: Dorothy R. Gagnier (904) 374-6077.

Inflammatory Bowel Disease, Sept. 19, Disney World Contemporary Hotel, Orlando. Contact: Arvey Rogers, M.D., (305) 687-1367.

Pediatrics for the Practitioner, Sept. 19, Bay Harbor Inn, Tampa. Contact: Herbert H. Pomerance, M.D., USF Dept. of Pediatrics, 12901 N. 30th Street, Box 15CE, Tampa 33612, (813) 974-4214.

12th Annual Gulf Coast Academy Internal Medicine Conference, Sept. 19-20, Pensacola Hilton, Pensacola. Contact: Margie Rickell, 8333 North Davis Highway, Pensacola, 32523, (904) 478-4460, Ext. 4792.

Options in the Treatment of Breast Cancer, Sept. 20, Inn at Indigo, Daytona Beach. For more info: Madhu Parikh, M.D., 875 Sterthaus Ave., Ormond Beach, 32074, (904) 677-6900, Ext. 3408.

New and Old Antiarrhythmic Therapy, Sept. 22, Edward White Hospital, St. Petersburg. For more information: Henry Mela Jr., M.D., 4908 First Avenue N., St. Petersburg, 33710, (813) 323-1111, Ext. 1331.

The Management of Professional in Organizations, Sept. 24-27, Peaceful Valley Lodge, Denver, Colorado. Contact: Sherry Mason, 4830 W. Kennedy Blvd., Suite 648, Tampa, 33609, (813) 873-2000.

Traumatic Spinal Cord Injury 1986, Sept. 25, Pensacola. Contact: Phyllis Connerly, 8383 N. Davis Highway, Pensacola, 32504, (904) 478-4460, Ext. 4178.

1986 Fall Conference on Pediatric Trauma, Sept. 26-27, Orlando Airport Marriott, Orlando. Contact: Patricia Brandt, P.O. Box 1393, Orlando, FL, 32802, (305) 244-2140.

Echocardiography 1986, Sept. 26-28, North Ridge Hospital, Ft. Lauderdale. Contact: Joseph Wanke, 5757 N. Dixie Highway, Ft. Lauderdale, 33334, (305) 776-6000.

Bereavement, Death and Dying, Sept. 26-28, Chinsegut Hill Educational Conference Center, Brooksville. Contact: Alan H. Tralins, M.D., P.O. Box 210, Clearwater, 33517-0210, (813) 462-7045.

Terrorism and Trauma: Would You Be Ready, Sept. 27-28, St. Joseph's Hospital, Tampa. Contact: St. Joseph's Hospital, (813) 870-4340.

OCTOBER

Symposium on Cardiovascular Diseases, Oct. 1-4, Marriott's Orlando World Center, Orlando. For more information: Juan J. Herran, M.D., 1414 S. Kuhl Avenue, Orlando, 32806, (305) 841-5144.

Florida Urological Society Annual Meeting, Oct. 2-4, Saddlebrook Resort, Tampa. For more info: G. Byron Hodge, M.D., (813) 974-2411.

Relapse Prevention Planning, Oct. 3, 1986, New World Landing, Pensacola. For more info: Barbara J. James, 5151 N. 9th Avenue, Pensacola 32504.

1986 Concepts in Medical Care, Oct. 4, Marriott Hotel, Jacksonville. Contact: Hortencia H. Espino, M.D., (904) 388-7243.

Controversies in OB/GYN and All That Jazz, Oct. 9-10, Park Suite Hotel, Jacksonville. Contact: Richard L. Myers, M.D., (904) 398-0004.

Fourth Annual Advanced Neuroradiology Seminar, Oct. 9-11, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, 12901 N. 30th St., Tampa, 33612, (813) 974-2538.

Diagnosis & Treatment of Adult Heart Disease, Oct. 10-11,New World Landing, Pensacola. Contact: Lane Edwards, 8333 N. Davis Highway, Pensacola, 32523, (904) 478-4460, Ext. 5120.

Cardiopulmonary Update '86, Oct. 10-12, Amelia Island Plantation, Amelia Island. Contact: Alberta Hipps, 1800 Barrs Street, Jacksonville, 32203, (904) 387-7563.

12th Annual OB/GYN Review Course, Oct. 12-20, Univ. of Miami, Miami. Contact: Patti Mundy, P.O. Box 016960, Miami, FL 33101, (305) 547-6716.

Annual Health Conference of Fla. Occupation Medical Assn., Oct. 17-18, Pier 66 Hotel, Ft. Lauderdale. Contact: Richard S. Myers, 2340 S. Arlington Heights Road, Arlington Heights, IL 60005, (312) 228-6850.

The Challenge of Cancer to our Community, Oct. 17-18, St. Joseph's Hospital, Tampa. Contact: Joseph G. Sinkovics, M.D., (813) 870-4250.

ACLS Provider Course, Sept. 20-21, Oct. 18-19, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., P.O. Box 18566, Tampa, FL 33679.

Fifth Annual Medical Laboratory Immunology Symposium, October 19-22, Holiday Inn Surfside, Clearwater. Contact: Herman Friedman, Ph.D., (813) 974-3281.

Annual OB Pathology Review, Oct. 21-24, Key Biscayne. Contact: University of Miami, Dept. of OB/GYN, P.O. Box 016960, Miami, 33101, (305) 549-6944.

1986 Family Practice Review, Oct. 22-26, Sheraton World, Orlando. Contact: William Stewart, JHMHC J-263, Gainesville, 32610, (904) 392-4321.

Arrhythmias: Interpretation, Diagnosis, and Management, Oct. 24-25, Orlando Hyatt Hotel, Orlando. For more info: Deborah Wilderson, 5808 S. Rapp Street, *#202*, Littleton, Co. 80120, (303) 798-9682.

42nd Regional Family Practice Weekend, Oct. 24-26, Sheraton Bal Harbour, Bal Harbour. Contact: Linda Marracinni, M.D., (904) 398-5667.

Medical Risk Management Seminar, Oct. 25, Hyatt Regency, Tampa. Contact: Wendy Rogers, P.O. Box 12099, Tallahassee, FL 32317, (904) 386-1111.

American Academy of Environmental Medicine 20th Advanced Seminar, Oct. 27-30, Sheraton Sand Key Resort, Clearwater Beach. Contact: Francis Waickman, M.D., P.O. Box 16106, Denver, CO 80216, (216) 923-4879.

Magnetic Resonance Imaging, Oct. 27-31, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Office Skills Workshops for Primary Care Physician, Oct. 29-31, Family Health Center, Orlando. Contact: Orris Rollie, M.D., 2501 N. Orange Ave., #235, Orlando, FL 32804, (305) 897-1514.

NOVEMBER

27th Workshop in Electrocardiography, Nov. 1-4, Sheraton Sand Key Resort, Clearwater Beach. For more info: Henry Marriott, M.D.. 601 12th St. N., St. Petersburg, 33705, (813) 894-0790.

Internal Medicine Update, Nov. 3-7, Colony Beach & Tennis Resort, Sarasota. Contact: Murray Grossman, M.D., 750 East Adams Street, Syracuse, NY 13210, 473-4606.

Current Issues and Controversies in OB/GYN, Nov. 6-9, Hilton Hotel, Lake Buena Vista. Contact: John T. Hanigan, M.D., (201) 456-4267.

Neonatal and Pediatric Respiratory Disease Conference, November 6-9, Holiday Inn Sufside, Clearwater Beach. Contact: R.L. Siegel, M.D., USF College of Medicine, 12901, N. 30th Street, Tampa 33612, (813) 972-3131.

Calcium Antagonists and the Kidney, Nov. 7-8, LaCosta Carlsbad, California. Contact: Murray Epstein, M.D., Univ. of Miami, Dept. of Nephrology, P.O. Box 016960, Miami, FL 33101, (305) 324-3103.

Approach to Risk Management and Malpractice, Nov. 7-8, Sheraton Bal Harbour, Bal Harbour. For more info: Gloria Allington, Division of CME, University of Miami, P.O. Box 016960, Miami, (305) 547-6716.

American Heart Association ACLS Instruction Course, Nov. 8-9, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Lasers for the Plastic Surgeon, Nov. 14-16, Orlando Regional Medical Center, Orlando. Contact: Registrar, (312) 856-1818.

Current Advances in Perinatology, Nov. 16-22, Frenchman's Reef Hotel, St. Thomas, Virgin Islands. Contact: Charles Bauer, M.D., Dept. of Pediatrics (R-131), P.O. Box 016960, Miami, 33101, (305) 547-5808.

Fourth Annual Arnold Palmer's Children's Conference, Nov. 19-22, Buena Vista Palace Hotel, Lake Buena Vista. Contact: Patricia Martinez, Dept. of Pediatrics, ORMC, 1414 South Kuhl Avenue, Orlando, 32806, (305) 841-5143.

Flexible Fiberoptic Sigmoidoscopy, Nov. 20-23, Wyndham Hotel, Orlando. For more information: Edward J. Kowalewski, M.D., 132 East 70th Street, New York, N.Y. 10021, (212) 517-7520.

Tenth Annual Seminar of the Fla. Assn. of Pediatric Tumor Programs, Nov. 20-22, Hyatt Hotel, Orlando. Contact: Cindi Butson, P.O. Box 13372, University Station, Gainesville, 32604, (904) 375-6848.

Nutrition in Pediatric Practice — 1986, Nov. 21, Bay Harbor Inn, Tampa. For more info: Herbert Pomerance, M.D., 12901 N. 30th St., Box 15CE, Tampa, 33612-4799, (813) 974-4214.

DECEMBER

Magnetic Resonance Imaging, Dec. 1-5, 1986, Dec. 8-12, 1986, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Refinements in Gastroenterologic Diagnosis, December 3-5, 1986, Contemporary Hotel, Lake Buena Vista. Contact: H. Worth Boyce Jr., M.D., USF Medical Center, Box 19, 12901 N. 30th Street, Tampa 33612, (813) 974-2034.

Innovative and Controversial Strategies in Rehabilitation, Dec. 3-7, Sheraton Bal Harbour, Miami Beach. Contact: University of Miami, Dept. of Ortho/Rehab, P.O. Box 016960, Miami 33101, (305) 547-6716.

First Annual Oncology Conference, Dec. 4-5, Grand Cypress Hotel, Orlando. Contact: Florida Hosp. Cancer Center, 500 E. Rolling Street, #305, Orlando 32803, (305) 897-7600.

Workshop on Clinical Hypnosis, December 4-7, 1986, Tampa Hilton, Tampa. Contact: Alexander A. Levitan, M.D., 2051 Long Lake Road, New Brighton, Minnesota 55112, (612) 786-1620.

Treating Cocaine Dependency, Dec. 5, Stetson University, Deland. Contact: Peggy E. Stinson, M.D., (904) 734-4121 Ext. 488.

Vascular and Pulmonary Diseases, December 5-6, 1986, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson, 5808 S. Rapp Street, #202, Littleton, CO 80120, (303) 798-9682.

Magnetic Resonance Imaging, December 8-12, 1986, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Emergencies in Internal Medicine, Dec. 9-15, Virgin Islands. For more info: University of Miami, Dept. of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.

International Conference on Hypertension in the Elderly, December 12-16, Wyndham Hotel Sea;World, Orlando. Contact: Bruce Robinson, M.D., (813) 974-2460.

JANUARY

Tenth Annual Oral Pathology Review, Jan. 10-14 and Jan. 31-Feb. 4, Miami. Contact: University of Miami, Division of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Nineteenth Seminar in Pediatric and Adult Urology, Jan. 21-24, Sheraton Bal Harbour, Miami Beach. Contact: Victor A. Politano, M.D., 6614 Miami Lakes Dr. East, Miami Lakes, 33014, (305) 687-1367.

Fourth Annual Doctors Hospital Winter Seminar, Jan. 24-31, Plaza Wood Creek, Mt. Crested Butte, Colorado. Contact: George T. Venis, M.D., 2295 Coral Way, Miami 33145, (305) 856-6121.

Oculoplastic Symposium 1987, January 24-31, University of Miami, Miami. For more information, contact: University of Miami, Department of Ophthalmology, P.O. Box 016960, Miami, 33101, (305) 964-0707.

Thirteenth Annual Vail Conference in Anesthesiology, Jan. 31-Feb. 7, Vail, Colorado. For more information: Sonja Craythorne, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101, (305) 547-6411.

FEBRUARY

Gastroenterology Update, Feb. 7, Mt. Sinai Medical Center, Miami Beach. Contact: University of Miami, Division of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Vail Symposium in Intensive Care, Feb. 7-14, Vail, Colorado. For more info: Sonja Craythorne, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6411.

Advances in Gene Technology, Feb. 9-13, Hyatt Regency, Miami. Contact: William J. Whelan, Dept. of Biochemistry, P.O. Box 016960, Miami 33101, (305) 547-6265.

Cardiopulmonary Rehabilitation Status '87, Feb. 10-14, University of Florida, Gainesville. Contact: Michael Pollock, Ph.D., Dept. of Medicine, Univ. of Florida, JHMHC J-277, Gainesville, 32610, (904) 392-0584.

Bascom Palmer Eye Institute 25th Anniversary Celebration, Feb. 19-21, Fontain Bleau Hotel, Miami Beach. For more information: Gaby Kressley, Dept. of Ophthalmology, P.O. Box 016960, Miami 33101, (305) 326-6031.

Third Annual Update on Neuro-Oncology, Feb. 24-25, Tradewinds Hotel, St. Petersburg Beach. For more info: S. Phuphanich, M.D., 12901 N. 30th St., Box 69, Tampa, 33612, (813) 974-3771.

Nineteenth Teaching Conference in Clinical Cardiology, Feb. 25-28, Sheraton Bal Harbour, Bal Harbour. Contact: Virginia McCars, Division of Research in Medical Education, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6491.

Selected Aspects of Internal Medicine, Feb. 28-March 6, Colorado, Telluride. Contact: University of Miami, Dept. of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

MARCH

Three-Day Diabetes Management Course, March 3-5, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Advances and Improvements in Hernia Surgery, March 12-14, Hyatt Regency, Miami. Contact: Arthur I. Gilbert, M.D., 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Cancer Conference Daytona Beach, March 13-14, Halifax Hospital Medical Center, Daytona Beach. For more information contact: Terry Bloom, M.D., (904) 254-4210.

Ninth Annual Family Practice Review, March 23-27, Holiday Inn Surside, Clearwater Beach. Contact: Charles Aucremann, M.D., 701 Sixth St. South, St. Petersburg 33701, (813) 983-6156.

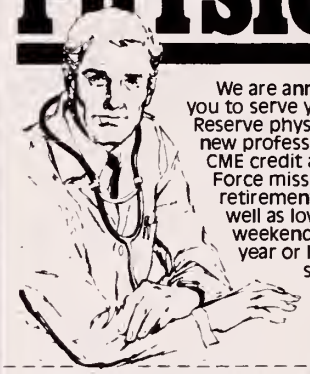
APRIL

Pediatric Oriented ACLS Provider Course, April 3-5, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Issues in Prenatal Care — 1987, April 10-11, Indigo Lakes, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Blvd., Daytona Beach 32014, (904) 252-4701.

1987 Radiation Therapy Clinical Research Seminar, April 23-25, University Centre Hotel, Gainesville. Contact: Timothy A. Brant, M.D., Radiation Therapy Division, University of Florida, JHMHC J-385, Gainesville 32610, (904) 395-0287.

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HQ 10 AF/RSH
Bergstrom AFB, TX 78743-6002

Name _____

Address _____

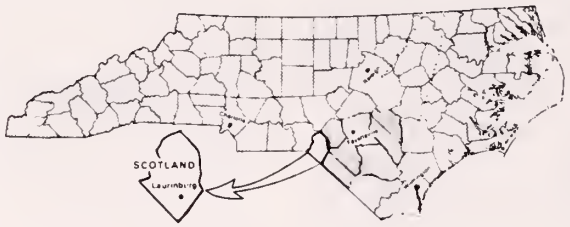
City _____ State _____ Zip _____

Phone _____ Prior Service? Yes ___ No ___

Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE



North Carolina

A strong medical community is seeking American Board Certified physicians to practice in a new 125-bed (all private rooms) not-for-profit hospital, state of the art equipped, located in a college community with over 25 major industries.

SPECIALTIES

Orthopaedics	Internal Medicine
Ophthalmology	(Gastroenterology)
Otolaryngology	(Pulmonology)
Obstetrics/Gynecology	Urology

Family Medicine

Please send CV in confidence to:
Physician Recruitment Committee
Scotland Memorial Hospital
500 Lauchwood Drive
Laurinburg, N.C. 28352
Attn: W.H. Davidson, M.D.

ADD NEW PATIENTS

A Nutrition Medical Centers franchise can help your practice grow. A logical extension of your professional knowledge and facilities, our proven system of nutrition counseling can create a new profit center for your practice. For more information on this exciting opportunity call (404) 872-4900.

NUTRITION MEDICAL CENTERS

1750 Peachtree St. N.W.
Suite 305
Atlanta, Georgia 30309
(404) 872-4900

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name:_____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____ _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word.
Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

DIAGNOSTIC RADIOLOGIST, Board Certified needed to join rapidly expanding hospital based solo-practice. Must have angiography/special procedures training/experience. Personable, willing to practice hands-on radiology. Large hospital located on the west coast of Florida, well equipped, MRI Pending. Box C-1329, P.O. Box 2411, Jacksonville, Fl. 32203.

A WEEK, A YEAR, A CAREER — Practice opportunities in Jacksonville, Miami, Orlando, Daytona Beach, Tampa. Options for permanent and/or locum tenens placements in all specialties. Trial associations with established practices in a variety of clinical settings. Call Suzanne J. Anderson at 800-833-3465 or write: Medstaff, Inc., P.O. Box 15538, Durham, NC 27704.

FAMILY PRACTICE — Orlando: Career opportunity BC/BE — Office, hospital practice in new office opening Nov. '86. Attractive financial package, guarantee, production bonuses, full insurance, share of corporation without investment. Send CV to Troy Overstreet, 120 Sunnytown Road, Casselberry, Fl. 32707, 305-339-7171.

OPENING FOR RADIOLOGIST: Diagnostic radiologist with interest and experience in mammography and ultrasound needed to staff new radiology office. Monday-Friday, 8-5. Florida License required. Salary negotiable. Contact K. Jay Adcook, M.D., 515 S. Orange Ave., Orlando, FL 32801, (305) 425-1518.

BOARD CERTIFIED FAMILY PHYSICIAN. Position involves patient care, Family Practice resident teaching and administration. Competative salary and fringes. Florida license required. Contact: Chairman, Department of Community Health and Family Medicine, University Hospital of Jacksonville, 655 West 8th Street, Jacksonville, FL 32209, (904) 350-6510.

30 BED SPECIALTY HOSPITAL in North Central Florida looking for associates to join existing practice in the following areas: orthopedic surgeon, plastic surgeon, neurologist, radiologist and two emergency room physicians. Florida license esential. Write P.O. Box 1268, Gainesville, FL 32602-1268.

NORTH CAROLINA, ASHEVILLE: Excellent professional opportunity for physician Board Certified or Qualified in EM at a regional medical center with 35,000 patient visits annually. Located in the region of the Great Smokies and Blue Ridge mountains. Excellent compensation, hourly rate and fee-for-service arrangement; professional liability insurance procured. Contact: Ruth Bone, Coastal Emergency Services, Inc., Ste. 217, Executive Park, Asheville, NC 28801; collect (704) 253-1256.

AGGRESSIVE, YOUNG, active and motivated F.P. looking for associate for office sharing leading to formation of group. C-1347, P.O. Box 2411, Jacksonville, 32203 or call (305) 842-5252.

TALLAHASSEE, FL — Position available for Board Certified Family Practice or Emergency physician at Ambulatory Care Center owned and operated by local physicians. Opportunity available to begin private practice with minimal start-up costs if desired. Exceptional Florida community. Physician group is small, progressive, consumer oriented, offering unique opportunity for the right M.D. Please contact Douglas Sherman, M.D. or Bill Riddle at Physician Care, (904) 386-2266.

DO YOU WANT TO SHARE a thriving dermatology practice? Do you enjoy year-round outdoor recreation? You should contact us. . .a progressive multi-specialty group of 61 physicians in a pleasant, growing community. We offer a liberal financial package and outstanding benefits. Send curriculum vitae and references to: Michael T. Anderson, M.D., Willmar Medical Center, 101 Willmar Avenue SW, Willmar, MN 56201.

FT. PIERCE, FLORIDA — Full time emergency department position available in a 240 bed hospital with an annual ED volume of 24,000. Candidate must be board prepared in emergency medicine. The hospital is centrally located between Disney World and Miami on Florida's Treasure Coast. Excellent compensation and malpractice insurance provided. Please send CV to Cheree Richards, EMSA, 8200 W. Sunrise Blvd., Plantation, FL 33322, or call (305 472-6922.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

PEDIATRICIAN — multi-specialty group in East Central Mississippi with three other pediatricians. Excellent fully equipped hospital, JCAH accredited. BC/BE. Initial salary with later productivity based income. Partnership in two years. No HMO/PPO affiliations. Send CV to Kenneth J. Reid Jr., M.D., Rush Medical Group, P.A., 1314 19th Avenue, Meridian, MS 39301.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

INTERNAL MEDICINE:Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

FAMILY PHYSICIAN: B.E. or B.C. for West Palm Beach practice. Florida license necessary. Opportunity for future partnership. 305-967-0234.

PHYSICIAN: Family Practitioner or Internist to associate with expanding office; Hallandale, Florida. Opportutnity to participate in new medical ventures. (305) 458-0100 or (305) 940-3533.

GENERAL INTERNIST, FAMILY PRACTICE, GERONTOLOGIST, EMERGENCY CARE MEDICINE 40 physician multi-specialty Group in West Palm Beach, Florida seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send C.V. to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 North Olive Avenue, West Palm Beach, Florida 33401.

OB/GYN PRACTICE opportunity on beautiful Amelia Island in Northeast Florida. Growth area with an established OB service and coverage available. Full service accredited hospital. Send C.V. to Alan Kent, Nassau General Hospital, 1700 E. Lime Street, Fernandina Beach, FL 32034.

INTERNIST — Internist, board certified/board eligible, wanted to join solo practice on Florida East Coast. Opportunity to step into a ready made practice with no investment and potential for full practice with in a year. Reply to Box C-1348, P. O. Box 2411, Jacksonville, FL 32203.

MULTI-SPECIALTY OPPORTUNITIES — NAPLES, FL. Expanding medical center seeks physicians in following specialties: OB/GYN, non-invasive Cardiologist, Infectious Diseases, Vascular Surgeon, Pediatrician, and Family Practice. Lab, x-ray, EKG, Mammo, and MRI on premises. Rapidly growing county. Send C.V. to Jerry Ruttman, Administrator, Naples Medical Center, 400 8th Street N., Naples, FL 33940.

PSYCHIATRIST — full-time position open for Board Certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient and limited inpatient on-call. Florida license needed. Reply to Box C-1349, P. O. Box 2411, Jacksonville, FL 32203.

TAMPA, FLORIDA — Excellent opportunity to become the primary physician of a well established growth oriented Family Practice in the fastest growing city in the South. Practice benefits include association with a specialty group, computerized management system, x-ray, laboratory, Spirometry, modern offices in pleasant surroundings. We are seeking a Board Certified or Board Eligible Family Practitioner, highly motivated and dedicated to the delivery of quality health care. Excellent base salary plus strong incentives based on revenues. We will provide assistance with interview and relocation expenses. If you would like to be an important part of our growing team, send your C.V. to John Q. Stauffer, M.D., 2919 Swann Avenue, Suite 205, Tampa, FL 33609; or call 813-870-3971.

MEDICAL COMPLEX in the lovely Gulf Coast community of Englewood, FL (Sarasota county) seeking well-qualified physicians (general and specialty) who would be affiliated with the Venice and Englewood Community Hospitals. Phone 813-474-7772 or 2011 Englewood Rd., Englewood, FL 33533, c/o Dr. Ryan.

Situations Wanted

VASCULAR — GENERAL SURGEON -BC- Vascular fellowship, presently in private practice. Desire multi-specialty group. Reply to Box 1340, P. O. 2411, Jacksonville, FL 32203.

42-YEAR-OLD, male internist-nephrologist, nine years of private practice experience, wishes to buy established internal medicine, or family practice, or to associate with a solo practitioner, or group. Other opportunities such as HMOs would be considered. Area of preference would be Broward, Palm Beach, including West Palm Beach, and Orange Counties. Other areas would also be considered. Please respond to Richard Eanni, M.D., 19 Fernandez Ave., New Windsor, New York 12550.

VASCULAR GENERAL SURGEON, vascular surgery fellowship. Board certified, desire group practice situation in Southern Florida. Call 206-326-5891 or write S. Goff, 528 18th Ave., Seattle, WA 98122.

INTERNIST seeks to purchase established medical practice in Florida, Reply to Box C-1351, P. O. Box 2411, Jacksonville, FL 32203 or call (305) 868-6361.

FAMILY PRACTITIONER, BC, Florida license looking for association, partnership or buying solo practice in Central Florida. Other areas considered. Reply, C-1198, P.O. Box 2411, Jacksonville, FL 32203.

GENERAL AND VASCULAR SURGERY with endoscopic experience. Now a chief resident in a university program. Available July, 1987. Desire solo, partnership, or group practice opportunity. C-1352, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE PHYSICIAN, New Jersey, Board Certified, Florida Licensed, with extensive experience in primary care, seeking employment opportunity in Southeast Florida. I am looking for office based work, full or parttime, no pediatrics. Available in Jan. or Feb. 1987. HMO's, group practices, or individual physicians having such opportunity can reach me: 201-334-1660 or evening 201-334-0363. Job must be within reasonable driving distance of Boca Raton where I will reside.

MEDICAL PRACTICE ADMINISTRATOR with over 15 years experience developing a general practice to 25,000 active pt. base seeks stable, long term situation dedicated to quality patient care and prudent business decision-making. Contact Dr. P. Callahan, Callahan & Associates, P.O. Box 1686, Largo, FL 34294, (813) 584-4275.

Practices Available

FLORIDA WEST COAST: Splendidly located, freestanding clinic for family practice or walk-in. Laboratory and x-ray. Rapidly expanding community. Nearby accredited hospital. Annual gross over $400,000.00. C-1321, P.O. Box 2411, Jacksonville, FL 32203.

FREE UROLOGY PRACTICE in upper Florida Keys. Introduction and support. Must be well qualified send Chief of Staff, Mariners Hospital, 50 High Point Rd., Tavernier, FL 33070.

UROLOGICAL PRACTICE for sale - Tampa Bay area. Urologist retiring. Available October 1986. Reply to Box C-1350, P.O. Box 2411 Jacksonville, FL 32203.

ESTABLISHED FAMILY—AVIATION MEDICINE PRACTICE, Miami, FL. Fully equipped office with assuable lease, fee-for-service, 24 hour week, good coverage and excellent growth potential. Gross in excess of $150,000. Easy terms, will introduce. Contact 36 Westward Dr., Miami Springs, FL 33166 or phone 305-888-1622.

FAMILY PRACTICE FOR SALE or lease. Well established, Pompano Beach, Broward County. 1,800 square ft. over 2,000 patients. Reply: 1531 S. Cypress Rd., Pompano Beach, FL 33060, 305-781-2211 or 752-9506, eve.

PALM BEACH Internal medicine practice for sale in excellent location. Very reasonably priced $65,000 including equipment. Write or call Lewis Practice Management, 1201 U.S. Highway One, Suite 430, North Palm Beach, FL 33408 (305) 694-0013.

TO SHARE BEAUTIFUL brand new office at Douglas Road (37 Ave.) across from Coral Gables hospital. Everything furnished, reasonable. Information, 448-0040.

FOR SALE: GENERAL PRACTICE. Doctor must retire. Excellent area in Miami, FL. Call 305-854-1599.

RADIOLOGY OFFICE FOR SALE OR LEASE. Established 8-year old private office being offered due to illness of owner. Services supplied include fluoroscopy, ultrasound, tomography, xeromammography and digital imaging. Most equipment less than 4 years old, will consider employment of associate radiologist up to two years. 145 Orange Avenue, Rockledge, Fl 32955, (305) 632-2914.

TAMPA. ACTIVE FAMILY MEDICINE/GERIATRIC medical practice available with fully equipped office. North Tampa area. Physician retiring. Will negotiate terms and introduce. C-1354, P.O. Box 2411, Jacksonville, FL 32203.

ANTICIPATING RETIREMENT. IM, CVB practice over 30 years in community. Central West Coast Fl. Need to be BE, BC. Two hospitals within three miles of office. Will stay, introduce. Office, practice available. C-1346, P.O. Box 2411, Jacksonville, FL 32203.

Real Estate

SPRING HILL, FL - 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease - owner will finance. (904) 596-4162 weekdays.

OFFICE FOR LEASE — 1500 sq. ft. of finished professional space in Gentry Building, U.S. Highway No. 1, North Palm Beach, FL. Prime location on ground floor. Suitable for any specialty. Available November. Phone 626-8300.

PRIME OFFICE SPACE FOR LEASE OR PURCHASE: 844 West Plymouth Ave., De Land, Fl. (1 block from West Volusia Hospital) Luxury @ 2000 Sq. Ft professional office, 2 bath, 1 pvt. bath/shower, 2 executive offices with pvt. interconnecting lounge/bath-shower, 4 exam rooms, common reception area with large waiting room, common business area. Lease: $2200.00 per Mo. Purchase: $185,000. Lease/Purchase available. Interested parties: (904) 736-6110.

RETIRING BOARD CERTIFIED OB-GYN selling or leasing completely equipped office. Capacity for 2 or more Ob-Gyns. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone 305-667-3677.

CAYMAN ISLANDS — modern 2 bedroom beach house on Cayman Brac. Superb snorkelling and scuba. Quiet out-island setting. Rental $350.00 per week. Dr. R. Lament, 2187 West 4th Avenue, Vancouver B.C. Canada (604) 733-5722.

BEACH FRONT LOT, Gulf of Mexico, Little Gasparilla Island near Boca Grande. Asking $110,000, consider plane or car as partial payment. Contact W. Coyner, M.D., P. O. Box 1429, Lakeland, FL 33802.

MEDICAL OFFICE FOR SALE: Jupiter Lakes Medical Park, Jupiter, Fl. Fully equipped and decorated includes operating room. Owner will consider part-time lease back. (305) 833-0899, or (305) 627-6333.

CRESCENT PLAZA located on A1A St. Augustine Beach, FL. Excellent location for medical office or health clinic in fast growing area near hospitals. Contact Helen Marett, 904-824-0491.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

WE BUY, SELL, LEASE SERVICE new and preowned medical instrumentation: Holter-Stress-Ultrasound-EKG Lab etc. Contact New Life Systems, Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065; 305-972-4600.

ATTORNEY FOR PHYSICIANS for business, professional regulation, records, malpractice, and standard of care issues. Vitae: Doctor of Science, Health Services Administration (University of Pittsburgh); Juris Doctor, Law (Creighton University); 20 years health-care experience; Professor; publications. Licensed to practice law in Florida, Michigan, and Nebraska. Contact: Robert Woody, Attorney at Law, Suite 205, 1950 Courtney, Fort Myers, FL 33901; telephone (813) 939-4321.

MEDICAL PRACTICE SALES AND APPRAISALS. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our Brokerage Division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004, 215-667-8630.

DO YOU WANT TO INCREASE YOUR BUSINESS? Then you should investigate the Florida Mall Business Centre. This prestigious new complex can offer maximum traffic exposure, fantastic location identity and increase business. At Debartalo's Florida Mall 855-6624.

LONG TERM FINANCING for starting/purchasing practices, diagnostic centers, equipment, office condos, buildings. $25,000 to $1,000,000. Western Financial, 1380 Miami Gardens Drive, N. Miami Beach, FL 33179, (305) 949-5900.

Equipment

WORD PROCESSOR — SONY. Take over lease - no downpayment, series 35 partial page, dual disk drive, 55 CPS printer. 14 months on lease at $730 per quarter. Option to purchase/investment tax credit. C-1357, P.O. Box 2411, Jacksonville, FL 32203.

Meetings

1987 CME CRUISE/CONFERENCES on selected medical topics — Caribbean, Mexico, Hawaii, Alaska, China/Orient, Scandinavia/Russia. 7-14 days year round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) and AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican & Alaskan cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746 (516) 549-0869.

TAMPA LAKEFRONT PROPERTY

7.6 Acres — 370' On The Lake

"One of a Kind" with that Southern Plantation Appeal!

Reasonably priced at $850,000 with terms
Bank appraised

Located on Lake Egypt, a 70 acre fresh water recreation lake, the closest lake to downtown Tampa.

Minutes from Downtown Tampa, International Airport, Major Interstate Highways, St. Petersburg, Clearwater, Schools, Shopping, Hospitals.

Contact: Anita Cleary, Broker Associate
(904) 596-9645 Office, (904) 683-2165 Home

JOYCE'S LIFESTYLE PROPERTIES
3193A Shoal Line Boulevard
Spring Hill, Florida 33526

GET MORE FOR YOUR ADVERTISING DOLLAR

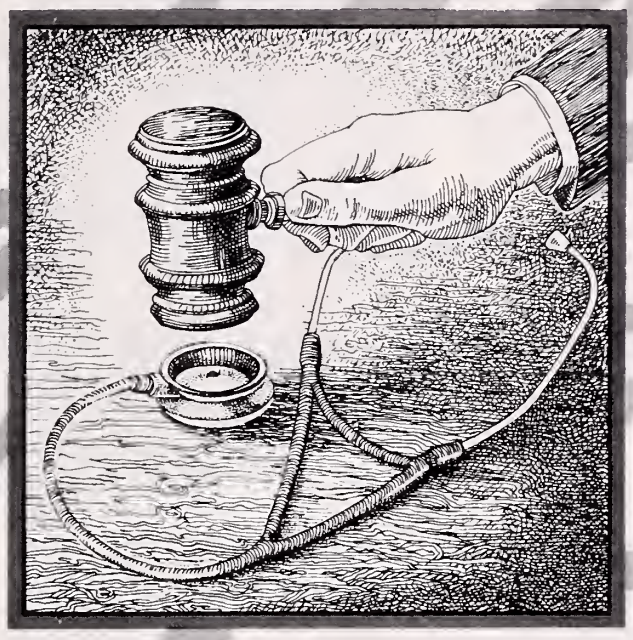
Purchase A Display Ad in the

Journal of the Florida Medical Association, Inc.

Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203

(904) 356-1571

Learn about legal issues affecting medical staffs



The AMA Hospital Medical Staff Section Eighth Assembly

December 4-8, 1986 • Las Vegas Hilton

Special Educational Sessions:

- Role of Medical Staff Legal Counsel
- Medical Staff and PRO Sanctions
- Antitrust and Credentialing
- Medical Staff / Hospital Board Relationships: Their Corporate Responsibility

Represent your medical staff.

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
Phone (312) 645-4747 or 645-4753

IMAGINE KNOWING THAT TODAY IS THE BEST DAY YOU'LL EVER HAVE.

If you had a progressive neuromuscular disease, every tomorrow would bring you greater weakness and more muscle waste. And the best day you could hope for would be the one you were having right now.

That's because most neuromuscular diseases progress day by day, gradually wasting a patient's muscles away. This muscle degeneration can't be halted. And, it can never be reversed.

At the Muscular Dystrophy Association, we're striving to put an end to twelve forms of muscular dystrophy and twenty-eight other neuromuscular diseases. Because we believe there are no incurable diseases—just diseases for which cures haven't yet been found. And because it's the only way that tens of thousands of people with neuromuscular disease can look forward to a better tomorrow.

MDA

Muscular Dystrophy Association, Jerry Lewis, National Chairman



He Figured That if the Recommended Dose Made Him Feel Good, A Double Dose Would Make Him Feel Better. He Was Wrong.

His reasoning was faulty because the amount of medicine you take is important. A medicine that can help you when taken correctly can make you sicker when taken incorrectly. In other words: *While one dose can do you good, a double dose can do you in!*

To avoid such dangers and to make sure that the drug you are taking does its intended job, follow the directions on the label exactly. If you don't understand them, ask your pharmacist or physician for help.

Medicines can cause a variety of reactions. Not all people have the same side effects but you should know what to watch out for.

When you get any prescription, be sure you know—

- **The name** of the drug
- **Its purpose**—what conditions does it treat?
- **How and when** to take the drug—and when to stop taking it
- What **food, drinks and other drugs to avoid** while taking it
- What **side effects** may result—are they serious, short-term, long-term, etc.?

If you have any questions about your prescription, *ask your doctor or pharmacist.*

A message from the Food and Drug Administration. For more material about being an informed patient, write to: FDA, HFE-88, Rockville, Md. 20857.

ADVERTISERS

Air Force
Recruitment . . . 694

Air Force Reserves
Recruitment . . . 722

American Institute of Medical Law, Inc.
Meeting . . . 676

American Medical Association
Seminar . . . 693

Army/Army Reserves
Recruitment . . . 669

Ayerst Laboratories
Inderal LA/Inderide LA . . . 662c
Premarin . . . 714b

Brown Pharmaceutical
Android . . . 670
Lipo-Nicin . . . 693

BellSouth Mobility
Service . . . 666

Curtis 1000 Information Systems
Computers . . . 694b

Eli Lilly & Company
Keflex . . . 662b

Fair Oaks Hospital
Service . . . 663

FMA Sponsored Insurance Plans
Service . . . 680

Florida Physicians' Insurance Company
Service . . . 662

Florida Power Corporation
Service . . . 679

GTE Telenet
Service . . . 675

HealthCare Communications
MediMac . . . 706

Info Systems
Computers . . . 706

Joyce's Lifestyle Properties
Real Estate . . . 726

Knoll Pharmaceutical Company
Vecodin . . . 694a

Marion Laboratories, Inc.
Cardizem . . . 678a

Medical Education Foundation of Miami
Meeting . . . 670

Nutrition Medical Centers
Service . . . 722

Roche Products, Inc.
Dalmane . . . 731

Scotland Memorial Hospital
Recruitment . . . 722

Smith, Kline and French Company
Dyazide . . . 714a

Upjohn Company
Motrin . . . 662a

Willingway Hospital
Service . . . 694

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D., Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

ROCHE
ME
MEDICATION
EDUCATION

The *New* Roche Product Books

- **Offer a supplement to, not a substitute for, patient contact**
- **Support your specific instructions to the patient**
- **Provide a permanent general reinforcement of your oral counseling**

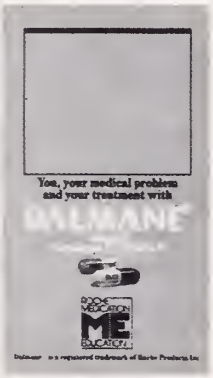
An ongoing Roche commitment to patient education

Roche has always believed that knowledge is each individual's key to good health and has long been committed to providing health care information to both professionals and the public. However, we have also always believed that the health care professional is and should be the prime source of medication information to patients. The Roche Medication Education (ME) program, begun in 1978, is one example of this commitment.

In the past seven years, over 50 million "WHAT IF" and "HOW TO" booklets have been provided by Roche for distribution to patients by physicians and other health care professionals.

Because you are the prime source of medication information for your patients, we invite you to look over the booklets listed below and request a complimentary supply of those applicable to your practice.

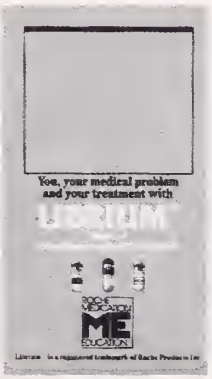
Complete the coupon and mail it to Professional Services Department, Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110.



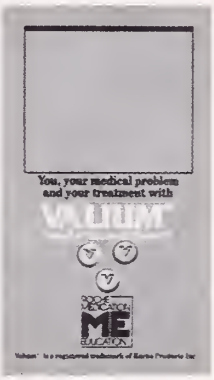
☐



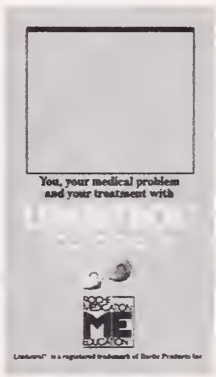
☐



☐



☐



☐

NAME

STREET ADDRESS

CITY STATE ZIP

ROCHE®
Medicines that matter
from people who care

ROCHE MEDICATION ME EDUCATION

We Wrote the Books on Patient Medication Education...

COLLEGE OF PHYSICIANS
COLL. OF PHYS. OF PHILADELPHIA
LIBRARY
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

You, your medical problem and your treatment with

DALMANE®

brand of flurazepam HCl/Roche



You, your medical problem and your treatment with

LIBRIUM®

brand of chlordiazepoxide HCl/Roche



You, your medical problem and your treatment with

BACTRIM™

brand of trimethoprim and sulfamethoxazole/Roche



You, your medical problem and your treatment with

VALIUM®

brand of diazepam/Roche



You, your medical problem and your treatment with

LIMBITROL®

brand of chlordiazepoxide and amitriptyline HCl/Roche



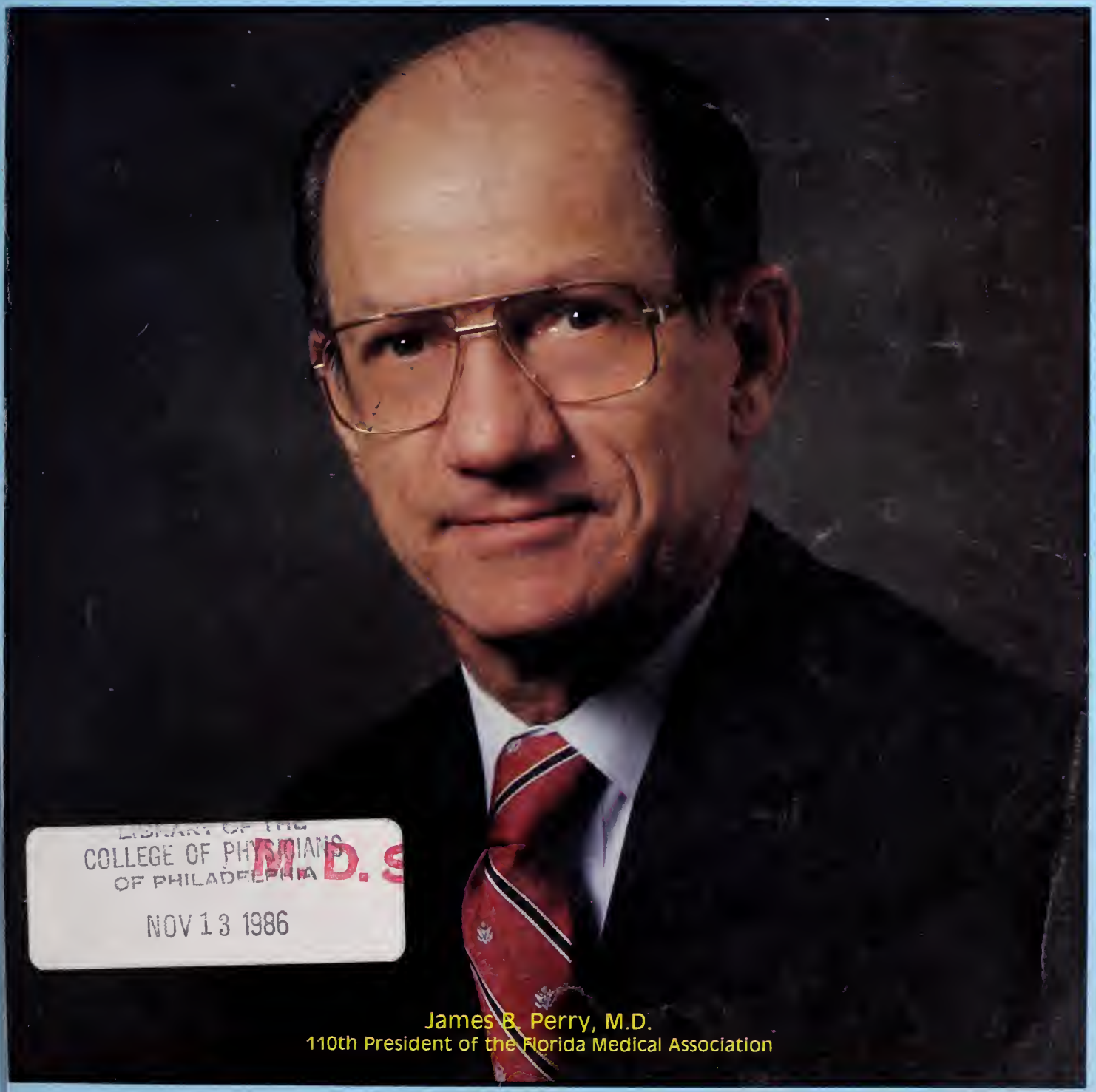
ROCHE

Copyright © 1986 by Hoffmann-La Roche Inc. and Roche Products Inc. All rights reserved.

To order a complimentary supply of Roche Product Books, please see preceding page.

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. OCTOBER 1986, Vol. 73, No. 10

STACKS



James B. Perry, M.D.
110th President of the Florida Medical Association

COLLEGE OF PHYSICIANS
OF PHILADELPHIA
M.D. S
NOV 13 1986

Select Quality!

The chart on this page can be used to compare the advantages of insuring with Florida Physicians Insurance Company. All medical professional liability insurance coverage is NOT the same!

QUESTION	FPIC	PPTF	ST. PAUL
Are your carrier's premiums non-assessable ?	YES	NO	YES
Is your carrier medical association sponsored ?	YES	NO	NO
Is your carrier Florida owned and operated ?	YES	YES	NO
Is the majority of your carrier's Board of Directors made up of physician's ?	YES	YES	NO

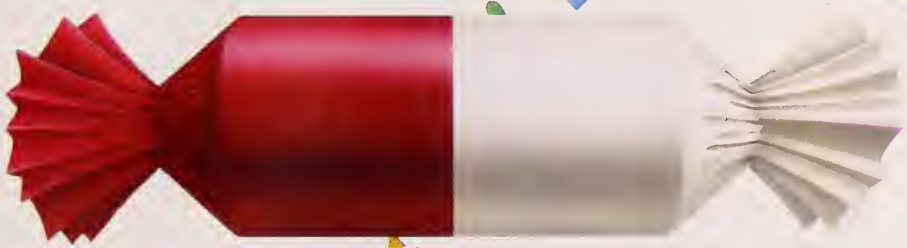
For more information call Ron Gladman:

FPIC FLORIDA PHYSICIANS INSURANCE COMPANY

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

10 YEARS

Thank you for your loyal support



DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

SK&F CO.



There's never been a better time for her... and PREMARIN®
(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®
(Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

The appearance of these tablets is a trademark of Ayerst Laboratories.

For atrophic vaginitis

PREMARIN®
(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2 ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria, edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985;67:496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semn Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

© 1986 Ayerst Laboratories

Ayerst® AYERST LABORATORIES
New York, NY 10017

T6194/886

ALWAYS ON CALL:

AT&T'S NEW DOCTOR'S SOLUTION ASSISTS YOU ROUND-THE-CLOCK WITH EVERYTHING FROM ACCOUNTS RECEIVABLE TO SCHEDULING.

Few doctors like to think of their practice as a business, but of course it is.

So the less you have to think about business, the more you can concentrate on medicine.

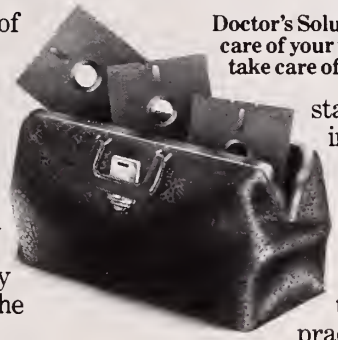
That's why AT&T tailored a complete hardware and software package specifically for the medical profession. The Doctor's Solution.

It's just one member of a whole family of Health Care Information Systems. AT&T Doctor's Solution provides total office management for single and multi-doctor practices.

Far from forcing you to change the way you run your practice, Doctor's Solution simply allows you to run it more efficiently with help like this:

Automated billing gathers all charges to each patient—including exams, tests and prescriptions—and automatically calculates a single, comprehensive bill.

Accounts receivable tracks all receivables, selects balance-forward or open-item statements, sets aging intervals, and spots delinquent accounts. All of which improve your collection rates.



Doctor's Solution software takes care of your paper work so you can take care of your patients.

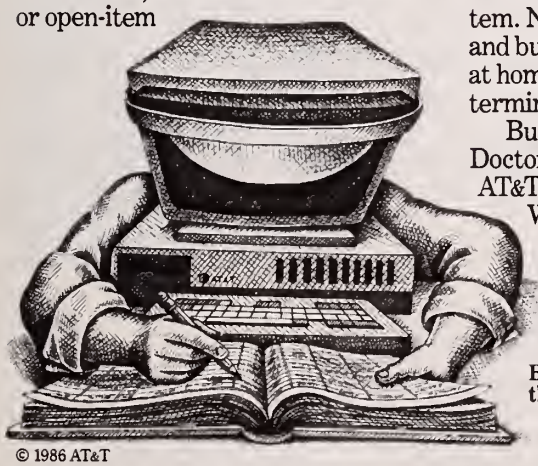
Practice management improves the flow of your practice with the ongoing maintenance of complete patient histories. Both clinical and billing information follow every patient through your office.

Patient scheduling by practice, doctor, week or month—including rounds and vacations—helps you get the most out of your time so you can give the most to your patients.

Third-party billing increases your cash flow by accommodating unlimited fee schedules and generating a variety of forms and invoices.

Remote access to your office system. Now you can get complete clinical and business information at the hospital, at home—anywhere there's a phone, a terminal or PC, and a modem.

But one of the nicest features about Doctor's Solution is that it's backed by AT&T's Small Business Connection. Which means our specialists in the medical field will make sure you get the right hardware, the right software and the right training.



By tracking who owes what, the system helps pay for itself.

As your practice grows, these specialists will help you keep your system right in step—accepting new doctors, new procedures and new diagnostics.

What's more, Doctor's Solution will work with every **UNIX**™ System-based computer AT&T makes. Just one more example of "The Computers With The Future Built In."

And if you have a problem? We not only have a Service Hotline; we even do over-the-phone software diagnostics.

It's all part of AT&T's unique approach to small business. You don't just buy a system. You buy AT&T's end-to-end responsibility for that system.



And you buy it from a single source with a proven past. And a very healthy future.

Give us a call at 1 800 247-7000. We'll show you how to get your practice a lot closer to perfect.

AT&T

The right choice.

© 1986 AT&T



QwikClaim

Question: *Which of the following is most important to **your** practice?*

☐ **Patient Care** ☐ **Management** ☐ **Money**

Answer: *No matter which of the above you choose QwikClaim can help you reach your goal.*

We Link Health Care Providers Directly to:
MEDICARE, BLUE CROSS & BLUE SHIELD
As Well As 40 Major Participating Insurance Carriers
Nationwide

Paperless Electronic Claims Submission Delivers Your
Claim Instantly & Error Free

- **Dramatically Increases Cash Flow**
- **Speeds up Claim Payments**
- **Cuts Administrative Costs**
- **Minimizes Paperwork**
- **Reduces Errors**
- **Easy to Use**

An Insurance Claims Express Path to Payment

Get a Qwik Check with QwikClaim

For More Info: Contact
Business Solutions Technology
676 West Prospect Road
Ft. Lauderdale, Florida 33309
Phone: 566-8513 561-1577
566-8535



FAIR OAKS HOSPITAL
QUALITY PSYCHIATRIC CARE

Fair Oaks Hospital at Boca/Delray is a psychiatric facility that values the judgment of the referring physician. Our specialty programs are led by full-time Yale-trained psychiatrists who value and utilize the medical model.

As the referring physician, you have the opportunity to collaborate closely with our staff physicians during all phases of evaluation and treatment.

A thorough patient evaluation is conducted on the Neuropsychiatric Evaluation Unit before treatment is administered. Thorough medical, neurological and neuroendocrine testing is performed, in addition to psychological and family assessments. Individualized treatment plans are carried out by our multidisciplinary treatment teams on our Adult Psychiatric Unit, Addiction Unit and Adolescent Hospital.

The Addiction program specializes in cocaine abuse and has pioneered in new treatments for the cocaine abuser.



Fair Oaks also has a unique reference source . . . cocaine addicts themselves.



Serving as the local sponsor for the **1-800-COCAINE** National Helpline for Florida callers, we have a direct link to drug users. Fair Oaks is able to apply Helpline information in the development of treatment and research programs.

The Adolescent Hospital is under the direction of a full-time board certified child and adolescent psychiatrist and includes a full-time school program. Specialized tracks exist for adolescent patients with psychiatric and substance abuse problems. Admissions counselors are available 24 hours a day to discuss all details concerning the hospital.

For more information call or write:

Admissions Coordinator
Fair Oaks Hospital at Boca/Delray
5440 Linton Boulevard — 305/495-3737
Delray Beach, FL 33445 — 305/495-1000

FAIR OAKS HOSPITAL
AT BOCA/DELRAY

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

OCTOBER 1986, Vol. 73, No. 10

CONTENTS

SCIENTIFIC ARTICLES

Bruce D. Shephard, M.D.	**759**	Update on contraception
Robert E. McCammon, M.D., F.A.C.O.G.	**760**	Unintended pregnancy — a U.S. problem
Bruce D. Shephard, M.D., F.A.C.O.G.	**763**	Oral contraceptives — an overview
J. Kell Williams, M.D., F.A.C.O.G.	**769**	Oral contraceptives — the long-term perspective
Michael S. Fernandez, M.D. F.A.C.O.G.	**772**	Nonsteroidal contraception — alternatives to the Pill
Robert W. Yelverton, M.D. F.A.C.O.G.	**777**	Contraception and the law: medical-legal trends affecting availability of contraception in the United States

SPECIAL ARTICLE

Richard J. Feinstein, M.D.	**783**	A review of the new statutory changes in Florida governing the policy of obtaining a medical license by examination

COVER

James B. Perry, M.D., was installed in Hollywood on September 20, 1986, as the 110th President of the Florida Medical Association. President Perry is a neurologist in Fort Lauderdale.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.* [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc., are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Florida Medical Association, Inc.

DEPARTMENTS

741 President's Page
Medical ethics
James B. Perry, M.D.

745 Editorials
James B. Perry, M.D.
Kenneth B. Babcock, M.D.
Meet Jim Perry
John D. Bloom, M.D.
The 112th Annual Meeting of the Florida Medical Association
Lee A. Fischer, M.D.
UCR fee schedule: the moral dilemma of it all
H. Frank Farmer, M.D., Ph.D.

753 Letters & Viewpoints

789 Medical Economics
Messages from Machiavelli
Jacques R. Caldwell, M.D.

795 Notes & News

796 Dean's Message

797 Encores!

803 Book Review

807 FMA Auxiliary
The FMA Auxiliary is a total way of life
Mrs. V.A. (Susan) Marks

810 Meetings

814 Classified Advertising

818 Index to Advertisers

818 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Pierre J. Bouis Jr., M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Karl Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.

From the AMA...

Get the standardized claim form you need, PLUS a FREE instruction booklet

AMA Uniform Claim Forms are:

- Required by federal programs such as Medicare, Medicaid and CHAMPUS
- Accepted by most major insurers
- Current and accurate
- Economical
- Easy-to-use
- Bar coded for faster processing



Order now– receive a new, fully detailed instruction booklet

For Faster Service...

Order today, with your MasterCard or Visa, by calling toll-free 1-800-621-8335. (In Illinois, call collect, 312-645-4987.) Or complete and mail the order card below.

Complete and mail today:

AMA Insurance Form
Book & Pamphlet Fulfillment
American Medical Association
P.O. Box 10946
Chicago, IL 60610-0946

Name_____

Address_____

City/State/Zip_____

Type of Form	# of Cartons
Single Form, 1-page, 100 per pad, ten pads.	_____ OP 501 @ $34.10/ctn. $_____
Snap-out Form, 2 part, original/carbon. (1000 per carton).	_____ OP 502 @ $49.50/ctn. $_____
Continuous Form, 2 part, original/carbon for computer printers (1000 per carton).	_____ OP 503 @ $51.75/ctn. $_____
Subtotal	$_____
Less 10% discount (AMA Members)	$_____
Sales tax (IL, NY residents)	$_____
TOTAL	$_____

For information on purchasing quantities of 10 or more cartons, call the AMA Order Department, (312) 280-7168.

- Payment must accompany order.
- Please allow 2-4 weeks for delivery.
- Prices subject to change without notice.

☐ Enclosed is my check/money order payable to the AMA for $_____

☐ Charge $_____ to my:

☐ MasterCard ☐ Visa

Card No:_____

Exp. Date:_____

Signature:_____

Phone # :_____

02BM001CF4

Medical ethics



Could we be on the verge of a Golden Age of Medicine?

Man is a wonderful, creative animal who has reason and free will. His destiny is limited only by the inability to utilize his boundless energy or unwillingness to allow himself to think. The opportunity is here. Accordingly, it is the desire of Florida Medicine to encourage all physicians to aspire to undreamed of potential and greatness. We hope to allow our membership "to be doctors," physicians who take care of, and have empathy for, patients.

We all owe a debt of gratitude to Luis M. Perez, M.D., and his determination and grit, which, together with the Florida Coalition for Liability Reform, have been instrumental, at least partially, in passage of legislation that allows us some respite in the never-ending battle for justice. We know that the unavailability and unconscionable cost of professional and general liability insurance in this state are a matter of social disgrace and have the attention of the United States Congress. In due time, just as apples are harvested or dropped from trees at the end of summer, these fruits of greed and avarice will fall away. Our cause is just and the reasons for it are righteous. We shall prevail, so do not lose faith or strength and continue to express righteous indignation in any fashion that is professional and espouses this philosophy.

Our mission this year, in line with the primary goals of the Association, is to address and strengthen some of the problems associated with the ethics of medical care. These include many of the considerations that rightfully should be considered in treatment of the whole person. This obviously encompasses all medical care, but we will also look at the emotional and physiological aspects of this care. Physiological implications impacting upon the emotional realm of the patient as a second order of illness must be considered. Family, friends, and business or job security impinge on these areas causing stress and, thereby, more anxiety. This problem also must be addressed. Empathy and emotional support impacted upon these parameters are of utmost consideration. In the elderly patient, problems of nutrition, hydration, bowel and bladder function must be considered in broad guidelines and interpolated to each patient as a very special individual.

We hope to encode a philosophical, broad principle approach that does not restrict or bind but emphasizes human dignity and justice. We need and desire input from every segment of the profession and its paramedical and support personnel. We do not believe that attempting to codify morality has any useful function, but we hope to address pressing medical problems in a forthright and objective fashion. This could include an evaluation of AIDS and related subjects. It will involve in-depth evaluation of substance abuse and its implications on society, both from the destructive standpoint of users and their frequent involvement in criminal activity as a support network for this abuse, and the production, distribution network which leeches on the vitality and finances directly and indirectly of all society.

We must also evaluate our professional conduct with a microscope and a jaundiced eye. This will include the philosophy of overcare especially in the terminally ill, the problem of justifying excesses, both through charges and testing, and the implication of

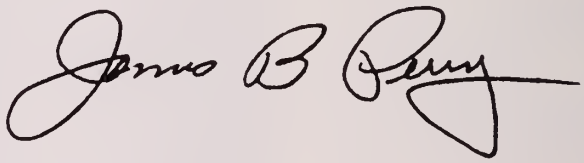
defensive medicine as a realistic gesture of concern or a cop-out of both conscience and principle.

Baby Doe philosophy as well as surrogate parenting and the implications of therapeutic abortion may also come under purview. The philosophy of transplantation and, to a lesser extent, placement of semivital structures from an orthopedic or circulatory standpoint to extend useful and functional life of all ages need to be addressed.

Above all, relationships with our peers in medicine, directly and indirectly, through our Judicial Council and credentialing will be factors of consideration. Implications of these and other tenets of ethics that come to light through program development and impact on our everyday practice and lives must be evaluated. How well we perform these microscopic introspections may well lead to a codification of philosophy that will determine how we react in the next century and how our younger physicians approach total health care delivery. Above all, we shall strive to improve the profession from our own view of it, because we are doctors whose primary purpose is to care for the sick and help to succor them in their hour of need.

It seems that we as physicians have reacted, justifiably perhaps, to the barbs of those jackals who have collectively nipped at our heels over the last two decades. Some of this has been caused by our own poor actions, often incurring the rightful wrath of those who "love to sue the doctors." On the other hand our indignation at these vituperative attacks has caused us often to stoop to the level of the curs, and then to our own disadvantage react ineffectively leading to more frustration. The resulting depression, to my way of thinking, has permeated the profession to an unreasonable degree. In this reinstitution of ethical considerations it is hoped that our profession may, through altruism, examine itself and its true mission in such a way as to purge ourselves of this unnecessary blight. We shall overcome, and in doing so strengthen ourselves, our commitment and effective quality of patient care. Dignity, justice and honor will prevail and be strengthened.

Your input, participation, and constructive criticism as a physician are solicited with the warmest and deepest feelings. God bless you.





Health Care At Its Best: Air Force Medicine

Air Force medicine is one of our best benefits, and, with your help, we'll keep it that way. The Air Force needs physicians such as you to become members of our health care team.

Most administrative responsibilities are in the hands of others, giving our physicians the time to give their full attention to the patients' needs. Our hospitals are staffed with dedicated, competent professionals.

You'll find you will have time for your family, and to keep abreast of the latest methods and technologies that you don't have time for now. We also offer unlimited professional development and financial security.

If you're considering a change, consider Air Force medicine. To find out more about Air Force medicine, contact your nearest Air Force recruiter. Experience health care at its best.

Contact: Coral Gables — (305) 444-0503; Gainesville — (904) 378-5102; Tampa — (813) 722-5014; EOE.

AIR FORCE

A great way of life.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5mg Buccal/10mg Oral/25mg Oral

Methyltestosterone U.S.P. Tablets

ANDROID®/F

Fluoxymesterone U.S.P. Tablets, 10mg







James B. Perry, M.D.
110th President
Florida Medical Association

James B. Perry, M.D.

Jim Perry has a mind that is running at full speed, and is blessed with a body that can keep up with the pace.

We met as general rotating interns at Mound Park Hospital, St. Petersburg, in 1956. Jim and his wife, Peg, were the youngest of our group, and also the center couple in our small group of 11 interns and two residents. Our wives shared rooms on the OB service. We followed similar paths to the U.S. Air Force as Flight Surgeons. Jim was stationed in Louisiana with the Strategic Air Command, receiving special commendation for his work.

After his Air Force service, Jim returned to Florida to set up a solo general practice in Pompano Beach-Ft. Lauderdale. Taking on Jim's practice as a locum tenens for brief periods over two years, I learned first hand how much time and dedication Jim gave to his patients, and the loyalty and respect his patients had for him.

In 1964 he left general practice, taking a three year residency in neurology at the Mayo Clinic. Again he returned to south Florida, this time to establish a neurology practice. To the distress of his neurology partners, Jim found it difficult to give up his interest in general practice and would take care of the whole patient — not just the neurology problem.

His energies were also absorbed helping to raise six healthy and equally hyperactive kids in swimming, little league, girls softball, cheerleading, track, football, and volleyball. He served as team physician for many Cardinal Gibbons High School athletic teams. Over the years Jim increased his interest and involvement in marathon running, jogging 30 miles a week in training and participating in many 26 mile marathon runs.

From internship on he has kept a lively interest in politics, both national and international. Narrowing the focus a bit Jim developed a growing interest in the BCMA and FMA, devoting increasing amounts of time, energy, and travel to help shape the attitudes and direction of medical practice in Florida. For years, while maintaining a busy neurology practice, Jim donated half his day off to care for indigent neurology patients in Broward County.

Even in recreation the Perrys have kept up a learning and exploring frame of mind. At each of our foreign posts Jim and Peg arrived full of questions and showing a desire to see and experience everything possible. They flew to the Khyber Pass, and went on foot from India to Pakistan after visiting aboard a leisure boat in the high Kashmir valley. In Africa Jim studied the birds and animals of Kenya, browsed the Indian markets for gemstones and stone carvings, toured our embassies in Kenya and Senegal. Always learning, questioning to broaden his experiences, Jim was indefatigable while pursuing new sights and sounds. Just as he works intensely, he enjoys leisure time at the same rapid pace.

The pervasive qualities which carry Jim through life are an intense high energy pace which he displays at work or leisure, demanding high personal standard a strong work ethic, and a drive to know and investigate.

Kenneth B. Babcock, M.D.
Assistant Secretary for Foreign Programs — Medical — Department of State
Washington, D. C.

Meet Jim Perry

I was asked to write a short note about Jim Perry, our new FMA President, to give the membership a picture of him by a longtime friend. It is a pleasure.

James Boyce Perry was born in Kansas City, Missouri, on June 16, 1931 and spent most of his early life in Milwaukee where his father, James C. Perry, Ph.D., taught biology at Marquette University. Jim graduated from the college and the medical school there. He then interned at Mound Park Hospital in St. Petersburg before spending two years in the U.S. Air Force. He then began general practice in Ft. Lauderdale in 1959.

With his serious approach to medicine and commitment to hard work he was very successful in his practice from every aspect except for the overwork and the burden it placed on his family. It was hard for him to say, "No." Partly because of this and an interest in neurology he took a residency at the Mayo Clinic and joined Ft. Lauderdale neurologists Will Dickens and Roger Schnell in 1966. He was still a workaholic but found himself with a night or two off during the week. That group turned out to be a farsighted one. Partly at Jim's instigation they purchased the first CT scanner in the Southeastern United States, only the twenty-first one manufactured, before anyone knew how important these would become. They have kept pace with the available technology and now are working with their magnetic resonance imaging.

Despite this progressive approach, Jim is full of old-fashioned ideas, things like treating people fairly, doing his best for his patients, loving his family, being active in civic affairs and keeping the faith. He and Peg have raised six fine children, all of them through college and Ted in medical school in Gainesville. He believes in paying his dues and putting something back into the system that made all of our medical careers possible. After all these years he still finds himself rolling out to the emergency room in the middle of the night, manning the indigent neurology clinic, doing high school football physicals, going to meetings, meetings, meetings. Many years back, his was a voice crying out in the wilderness when he opposed the idea of the hospitals paying the physician for indigent care. Free care for the poor was part of traditional medicine, our inheritance, a debt we owed for the gifts we have received. It did not sell.

He is blessed with energy. I could never keep up with him. We have travelled over the world together and when the rest of us were wiped out with jet lag, there he was, stepping higher than a blind horse and ready to charge. He is going to need this energy.

He is simply a good person, loaded with basic values and without pretense or guile. That he was chosen as President of the FMA is in my mind a tribute to the people in our organization. He has a lot of good ideas and he deserves our trust and support. We are lucky to have him as our spokesman. Let's give him his chance.

John D. Bloom, M.D.
Ft. Lauderdale

The 112th Annual Meeting of the Florida Medical Association

The 112th Annual Meeting of the Florida Medical Association was held September 17-21, 1986. The meeting, held at the Diplomat Hotel in Hollywood, was moved from its usual May date to September beginning this year. The change in dates gave Luis M. Perez, M.D., the distinction of serving as FMA President longer than anyone else.

Another change in format this year was that the first session of the House of Delegates began on Thursday morning instead of Wednesday. Any thoughts I may have entertained about driving down Thursday morning were quashed when the traditional *JFMA* Editors' Dinner was changed to a Wednesday luncheon. The winners of *The Journal's* Ninth Annual Awards Contest for County Medical Society Bulletins were announced at that time. They were:

Category I — General Excellence • Newsletter Format — First Place: *Escambia County Medical Society Bulletin*; Special Citation: *DCMA Update . . .* Magazine Format: *First Place: The Stethoscope* — Volusia County Medical Society; Special Citation: *Miami Medicine*

Category II — Most Improved Bulletin • First Place: *Central Florida Physician* — Orange County Medical Society; Special Citation: *CAP Scan* — Capital Medical Society

Category III • Best Editorial — First Place: *The Stethoscope* —"Social Darwinism or the Social Gospel — A Matter of Conscience" — Volusia County Medical Society

Category IV • Best Regular Feature — First Place — *Central Florida Physician*, Orange County Medical Society

Category V • Special Recognition — First Place: For its effective use of photography and art — *Escambia County Medical Society Bulletin*; Special Citation: For its attempt to raise political consciousness — *Sarasota County Medical Society Newsletter*

The House of Delegates is the policy making body of the Association where delegates debate and vote on reports and resolutions. Each county is represented by one delegate for each 50 FMA members, and, also new this year, each FMA recognized specialty society has one delegate. The first session of the House consisted of ceremonial events and awards, and referral of business to the appropriate reference committees. That evening the FMA Auxiliary hosted a highly successful dinner cruise along the Intracoastal Waterway.

Reference Committees met Friday morning. All business of the House was referred for open discussion before one of the committees. Delegates to the House serve as the committee, and hear testimony on all items referred to them. They then adjourn to closed session and write a report of their recommendations which is acted upon by the House at the second and third business sessions.

The Good Government Luncheon, sponsored by the FMA, Auxiliary and FLAMPAC, was held on Friday. John Coury, M.D., President of the AMA, was there to greet us and discuss some of the problems physicians face throughout the country. The guest speaker was to be Robert E. Windom, M.D., past president of the FMA and now Assistant Secretary of Health in the Department of Health and Human Services, but he was unable to attend at the last minute. In his place he sent Dr. Frank Young, Commissioner of the Food and Drug Administration, who discussed the changes taking place in the public health service and the FDA.

One of the main reasons that the meeting has been held at the Diplomat for so many years is that there are very few hotels in Florida large enough to

house the meeting. If the Annual Meeting consisted only of the House of Delegates and its reference committees, almost any hotel with a large meeting room would suffice. But, a large number of other meetings are held simultaneously besides the House. Many specialty societies held scientific sessions and seminars during the times that the House or reference committees were not meeting. For instance, the Florida Academy of Family Physicians held a "Dialogue" session with speakers discussing hypertension, infections, cost effective practice, and cardiac emergencies. The Florida Society of Rheumatology sponsored a section on current techniques in joint replacement. Other sections discussed lymphoma, gynecologic problems, and cardiac disease. The FMA also held a risk management workshop, a symposium on the care of the aging patient, and a section on chemical dependence.

The second session of the House recessed late Saturday afternoon so everyone could get ready for another new event this year, the presidential inauguration ceremony. The ceremony was modeled after its AMA counterpart. The FMA officers, Board members and the presidents of each component medical society dressed in black tie and were seated on the dias. Drs. Edward Annis and Rufus Broadaway introduced each individual to the assembled guests. Dr. Perez gave his farewell remarks and then James B. Perry, M.D., was inaugurated as the 110th President of the FMA. Following Dr. Perry's address, the members and guests were greeted by President Perry and Mrs. Susan Marks, the newly installed Auxiliary President, at an outdoor reception.

The final session of the House began Sunday morning with the election of officers. James G. White, M.D., of Ormond Beach, was elected President-Elect, while Kay K. Hanley, M.D., of Clearwater, was elected Vice President. At one point in the morning Guy T. Selander, M.D., Speaker of the House, interrupted the proceedings to introduce Dr. Windom who surprised and delighted us by flying in from Washington to greet his good friends and colleagues and update us on his new job at HHS.

The House of Delegates completed the reference committee reports and adopted many new policies. Each member will receive the official proceedings, but here are the highlights of our actions:

- Called for the Board of Governors to study the issue of unified membership with the AMA and report back at the next Annual Meeting.
- Urged the government to immediately halt the expansion of federal capitation programs until the problems that have surfaced in Florida and elsewhere can be thoroughly evaluated.
- Requested that the FMA Board of Governors study the desirability of requesting that the state legislature make FMA membership a requirement for licensure.
- Requested that the FMA try to institute a requirement that all generic drugs be labeled with both trade and generic names.
- Opposed any federal legislation that would in any way limit the use of sample medications by physicians.
- Actively opposed any effort by the Florida Legislature to mandate acceptance of any third-party payor assignment as a condition of licensure.
- Referred to the Board of Governors a report of the judicial council that would establish a statewide grievance reporting system.

Lee A. Fischer, M.D.
Associate Editor
West Palm Beach

UCR fee schedule: the moral dilemma of it all

There are many moral and ethical issues facing physicians today. One of the more pressing, although often unthought of, is the moral dilemma that physicians face while trying to operate under the "usual, customary, and reasonable" fee schedule which Medicare has fostered upon us. It is a system that truly tries the moral fiber of all physicians and causes the doctor to often choose between self-survival and the slow erosion of his or her moral and ethical standards. To be sure it is an insidious process, one by which the moral objections to a course of action are stripped away gradually until physicians may not even feel that there is any dilemma at all.

Let me explain. I assume that all readers of this article are familiar with the reimbursement system of medicine which is based on the "usual, customary, and reasonable" (UCR) concept which was developed by the insurance industry in the 1960s. The "usual" component refers to the physician's common charge for a particular service; "customary" is the fee profile of other physicians in the community providing the same services, which is then fixed at an arbitrary level such as the 75th percentile of all fees charged for that service. The "reasonable" component is the lowest of the "usual" or "customary fees." With this system it is obvious that it is in the best financial interest of the physician to establish his fee schedule at the higher end of the scale, as this will be one of the factors considered in the equation for reimbursement for services rendered. Collectively speaking, it is better for the individual and for all physicians in a given area to charge high fees as this will favorably influence the customary charges and lead to a higher reimbursement for that particular geographic area.

Many physicians learned to their chagrin what happened to those who had low fee profiles in the fall of 1984 when the present fee system was enacted and their respective reimbursement schedule was frozen far below that which would be commensurate with the services they provided. There are those who would say that those physicians who had continued to maintain a low fee profile up to the freeze had no one to blame but themselves. However, many physicians, for matters of conscience and in an attempt to try to help their patients, kept their fes at the margin of financial survivability. For many doctors this was a deeply moral, ethical consideration for which they were not rewarded, but severely punished when the Medicare freeze was inaugurated in October, 1984. While they were previously existing on the edge of financial survivability with the cost of overhead, etc., those physicians are now living with a fee profile that was inadequate in 1984 and shameful in 1986.

All of these happenings have not been lost on already practicing physicians and those about to enter practice. The message is clear. If you do not want to be saddled with a fee reimbursement system that may break you financially, you had better be on the high side with your own fee profile. Physicians setting up practice are quickly advised to establish their fee schedule as high as possible. Many physicians already in practice have vowed that they will never again be caught on the short side of the UCR system if they ever get the chance to raise their fees.

What is the moral and ethical dilemma? The dilemma is that an individual, in this case a physician, is forced to make a decision which on the one hand may be morally just, but on the other may also be tantamount to financial ruin. If a person decides on a fee which he considers to be moral, but which consigns him to a financial hardship in his practice and may lead to reduction of his services in other areas in order to maintain a solvent practice, is this the proper moral choice?

What is happening and will continue to happen in a system that poses such an unsolvable problem is that the moral aspect of the question will become a nonissue as we will not consider it as a moral question, but will rationalize it on other levels. This is really the only way for an individual to survive on an intellectual basis: to ignore the moral question, and, if it is addressed, to rationalize any answers that may not be morally right.

This is a normal human reaction when faced with such a terrible dilemma and one which has led to tragic consequences in other situations. We have a modem day example in which individuals were forced to make moral decisions in an environment where a morally just decision may not be rewarded and could well be to the long-term detriment of that individual. This is, of course, Vietnam. So as to not prejudice my comments on this, let me state that I am a Vietnam veteran, a volunteer, a patriot I think, and an admirer of America's institutions, including the military. In Vietnam, the military was put in much the same moral dilemmas as physicians are today. It was more subtle, but just as insidious and just as ominous. In that war, the road to promotion was greatly influenced by the "body count," supposedly the summary of the enemy killed in a particular action. In a gorilla-type war, many civilians and noncombatants were often killed and in the beginning of the war some of these were inadvertently added to the body count. Commanders soon saw that this was an added plus in their efficiency reports. As commanders rotated on the 12-month assignments, each succeeding generation of officers found it easier to ignore the fact that the body count might include many noncombatants and it became acceptable to some to lie outright about body counts. Once the moral question is subjugated, it is no longer an issue of any further decisions involving that subject. If morality is not considered, then an immoral or at the least an amoral decision can be made with less soul-searching and conscience-seeking. By the time matters get to this point, the rationalization has softened the moral versus immoral issue and the decision becomes an "acceptable course of action."

The other choice many military commanders faced if their body count total was not up to par was to get bad efficiency reports from their superiors, which could end their careers and affect their personal lives and families. Is it moral to make a decision that could potentially destroy or have such everlasting effects on that person? Philosophers and humanitarians can debate that issue indefinitely.

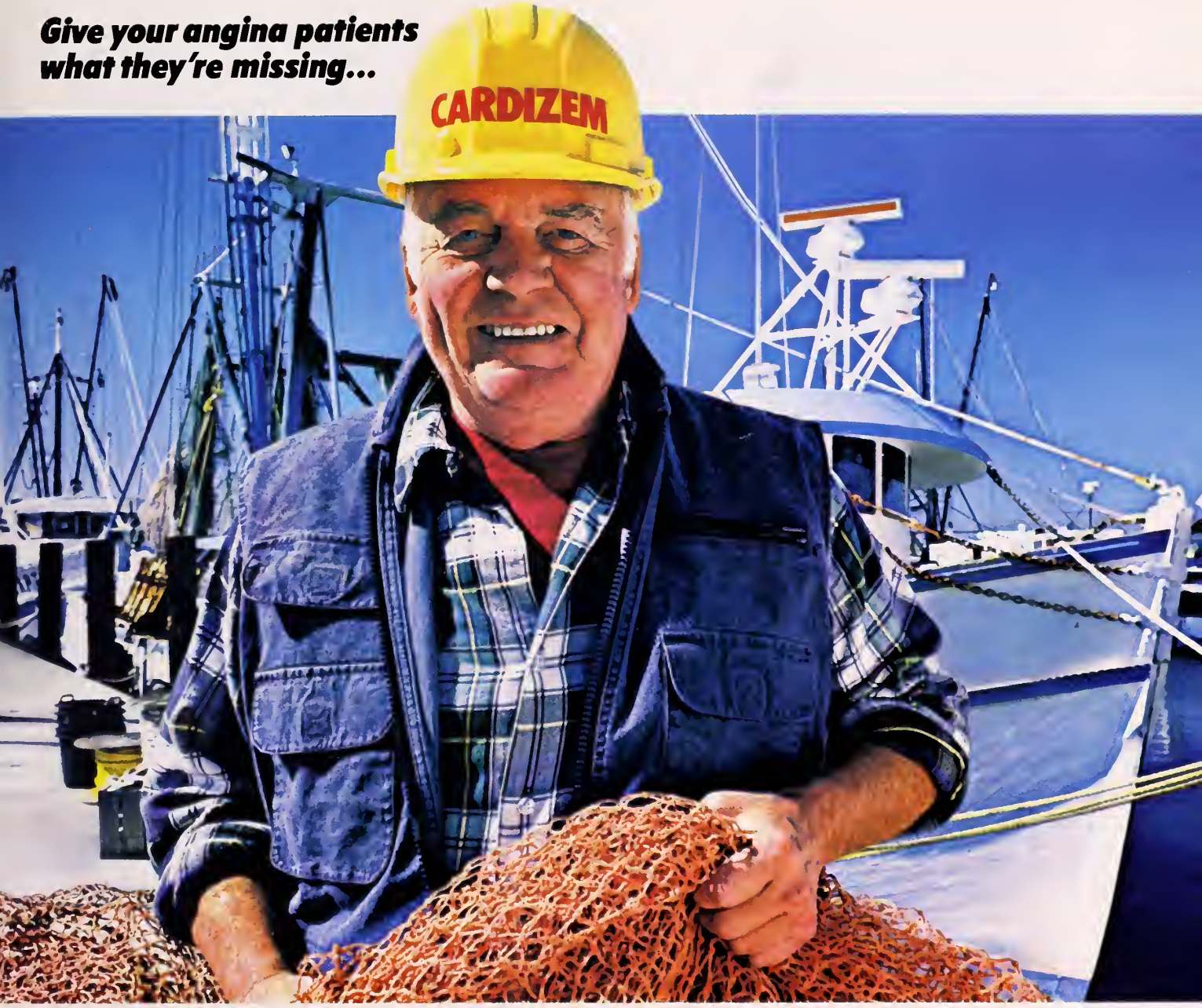
The point of it all is that physicians, like many military officers of Vietnam, are forced into a decision that seemingly has few good options. To decide on a purely moral course of action based on adherence to a fair fee schedule for his patients may make that physician vulnerable to some very unpleasant consequences such as the shutting of his office if he cannot pay his overhead and the rapidly escalating malpractice premiums. There are those who could argue convincingly that this is just as immoral a decision as the first option, as the possibility of depriving a segment of society of a physician's care cannot be supported from an ethical or moral standpoint.

There is no justification for any group to be in a position that requires such decisions of its members. Regardless of the economic considerations of the UCR fee system, the plain fact is that medicine in good conscience cannot, and should not, be made to live within a framework where the moral decision may be the immoral decision or vice versa.

It is time that the UCR fee schedule became a relic of the past to be debated and analyzed in future classes when discussing the subject of the history of medicine and its ethical and moral impact on both society and physicians.

H. Frank Farmer, M.D., Ph.D.
Historical Editor
New Smyrna Beach

Give your angina patients what they're missing...



CARDIZEM®: FEW SIDE EFFECTS

diltiazem HCl/Marion

- ***Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate***
- ***Proven efficacy when used alone in angina[1]***
- ***Compatible with other antianginals[2,3*]***
- ***A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD[4,5]***

***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.



CARDIZEM® FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

diltiazem HCl/Marion

60 mg tid or qid

Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/posthatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***3.*** *Johnston DL, Lesaway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

Another potent benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137

0246M6

For Your Benefit...

From The Florida Medical Association Sponsored Insurance Plans.

Diagnosis: FMA Members and Employees, Need Dependable, Comprehensive Coverage In Medical Care, Life, Disability and Dental At Economical Group Rates

Treatment: Enroll NOW in Your Florida Medical Association Sponsored Insurance Plans

Prognosis: Excellent. FMA-SIP Offers Flexibility, Convenience, Efficiency In An Insurance Package Designed Exclusively For You.

•Major Medical •Dental •Short-Term Disability •Life And AD&D

☐ Developed from your specifications by your Association and offered exclusively to FMA members and their employees. Dependents coverage available for Medical and Dental benefits.

☐ Marketing by Florida's leading insurance consultant, Brown and Brown, Inc., for further information contact us at the toll free number below.

☐ Underwritten by one of America's largest and strongest insurance companies, Mutual of Omaha.

☐ Administered by FLAMEDCO, Inc., highly regarded for rapid, efficient claims and enrollment administration and a wholly owned subsidiary of your own Florida Medical Association.

FMA/SIP Offers You Great Flexibility. You Choose The Coverage You Need:

Major Medical, Million-dollar protection with your choice of $200 or $500 annual deductibles and the new Medical Deluxe Plan.

Dental, Benefits of up to $1,000 per person each year. Optional if you elect Major Medical.

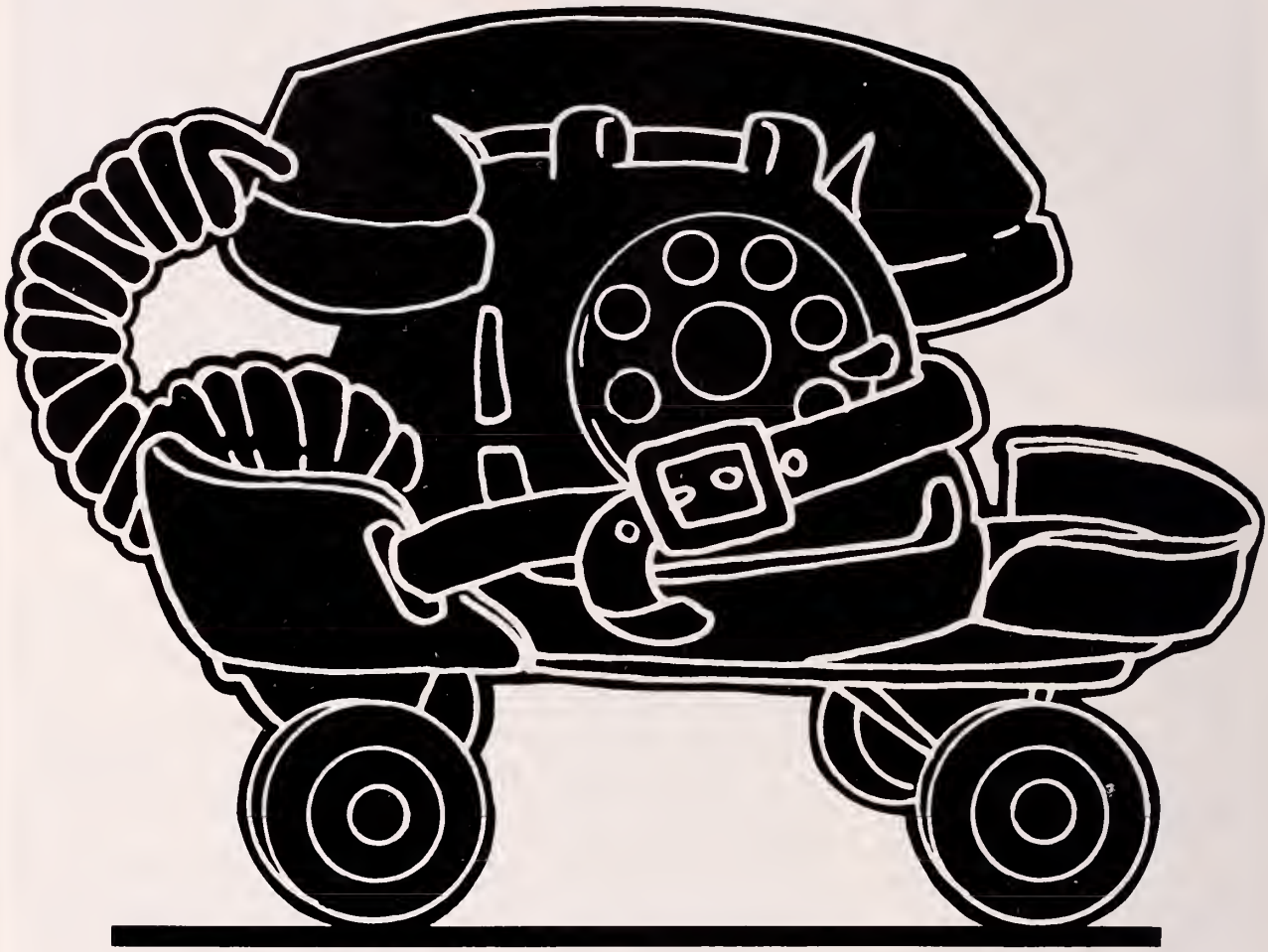
Life, Group term life insurance coverage for you and your employees. You select coverage level from $10,000 to $100,000.

Disability, If you elect life insurance, you also may choose from among four short-term disability options, either 13-week or 26-week coverage with or without maternity.

P.O. Box 4938
Jacksonville, Florida 32201



Florida Medical Association, Inc.
Sponsored Insurance Programs



Car Phones Explained.

A car phone is just a phone on wheels. Like the ones in your kitchen, your bedroom, your office. And for an incredibly affordable price, you'll find there's nothing simpler or more convenient than having a phone in *your* car. Maybe that's why BellSouth Mobility has put more phones on wheels than anyone in the Southeast.

For full details, call BellSouth Mobility today at **1-800-351-3355.** Because all the way from Jupiter to Florida City, we really are the phone company for your car.



The Phone Company For Your Car.℠

BellSouth Mobility
A *BELL*SOUTH Company

©1986 BellSouth Mobility

New drug sampling law a big nuisance

The recent legislative session in Tallahassee disgorged two pharmacy laws that are pernicious to physicians. The first, which has been well publicized, gives the pharmacist the right to diagnose and treat certain common cutaneous, allergic, gastrointestinal, and pain conditions. It has been well described and editorialized. The second is more expensive to us as physicians and more nefariously interferes with the way we practice. The second law requires physicians, as of October 1, 1986, who dispense medication samples, to suffer the time-consuming nuisance of labeling each sample container with each patient's name, date and doctor's name.

Most doctors should resent this unnecessary infringement on our time and the additional overhead burden. The time consumed to fill out each label is only about 30 seconds but if you are the average doctor who passes out 30 sample bottles each day, then you are tying up your rooms and personnel for an additional fifteen minutes each day. So why make a fuss? Because the fifteen minutes each day translates into an hour and quarter each week and 60 hours each year. At an overhead cost of $60.00 an hour, that is $3600.00 per year. At $100.00 an hour overhead, it is $6000.00 per year. This is an overhead line item that can chew away an additional 6% of your net income.

Of course physicians can stop dispensing samples. This is exactly the goal of the new legislation. Cessation of sample use will add to the glee of some pharmacists who feel samples deprive them of prescription sales and, therefore, profits. I feel that eliminating samples from our practices is an inappropriate option.

Samples are helpful to the patient and the physicians for many reasons. First, we give samples to indigent patients or elderly folks, whose drug bills consume a significant percentage of their annual income. Despite our free medications, samples by no means satisfy the total prescription supply of these medically needy individuals. If I give a patient, whom I see every three months, a one or two-week supply of a nonsteroidal antiinflammatory drug, that small amount represents a miniscule portion of the patient's total medication requirement. But it does help the patient in a small way. Secondly, we give samples to those patients who frequently experience adverse reactions to medications. A few days' usage of free medication can help us to determine if such a patient can tolerate the prescribed medication prior to his or her investment in a large number of pills. And finally, we use samples to familiarize ourselves with the pharmacologic vicissitudes of new medicines when administered to our own patient population. This application allows us to verify the claims of the pharmaceutical company representatives and permits us to evaluate the drug in a "real world" situation that often differs from the milieu of the pharmacologic setting. Drug research projects are conducted utilizing a well defined, younger, healthier population, in which some medication reactions that might arise in a more sickly group may not appear. Samples allow us to test the drug among our unique patient populations with no cost to the patient.

For these reasons drug samples are useful to doctors in the management of patients. Most of us despise the oblique technique of the recent legislation that would make us surrender sample use because of the imposition of an additional bureaucratic burden upon us.

This latest piece of legislative flotsam is only one in a series of laws that have permitted pharmacists to meddle in and muddle up the practice of medicine. Fifteen years ago pharmacists and physicians coexisted as professional partners in the patient care process.

Pharmacists did not diagnose and treat patients; most physicians did not dispense or sell medications. However, the pharmacists' lobby in the legislature has slowly etched away the spirit of collegiality that bonded together medicine and pharmacy.

The first of the pharmacy nuisancy laws was the generic equivalent law which gave the pharmacist unlimited license to substitute generic drugs for a brand name medication. This law, nobly disguised under the mantle of "consumer interest," was designed to enhance pharmacists' incomes since profit margins on generic drugs significantly exceed those on the popular, frequently used, brand name drugs. Most physicians did not object to this law until bioequivalency studies demonstrated that all generics are not biologically equal in patients. Federal regulations require a generic substitute of a drug to produce plasma levels (as defined in terms of area under the plasma concentration-time curve, time to maximum concentration, and maximum concentration) 70% to 130% of those produced by a standard, parent drug. Furthermore, the generic drug must satisfy this plasma concentration requirement in only 70% of the subjects in which the generic drug is tested. For many compounds this variation in bioavailability may be tolerable. For others, such a random variance in bioequivalence can trigger severe untoward events. Let me embellish this scenario with some examples from my own practice.

One of my research fellows at the University of Florida was exquisitcly allergic to laboratory animals. To offset this sensitivity he medicated hemself with 10 mg. of Deltasone on days that he conducted experiments with animals. After many months of this routine he experienced an anaphylactic reaction during an experiment on his rabbits even though he had premedicated himself in the usual fashion. Subsequent investigation demonstrated that he had taken his prednisone from a newly filled prescription container. The pharmacist had substituted a "cheapy" generic prednisone manufactured abroad for the brand name prednisone that he had been acccustomed to consuming. The generic medication was not absorbed properly and thus the protection against anaphylaxis was not achieved.

A second patient, who had rheumatoid arthritis, developed a "nitritoid reaction" following an injection of gold sodium thiomalate. Her reaction was characterized by flushing, hypotension, and a cardiac arrhythmia. Such reactions occur with gold sodium thiomalate but much less frequently with aurothioglucose (another form of injectable gold salt). She was subsequently placed on aurothioglucose which she tolerated with no difficulty. Since the patient lived several hours away from my office she purchased her gold from a local pharmacist and had her family physician administer it to her. Unfortunately one pharmacist substituted the gold sodium thiomalate for the aurothioglucose and the patient experienced another severe, life-threatening reaction when the substituted gold was injected. These two forms of gold salts are chemically dissimilar, and have different side-effect profiles. The pharmacist should have never interchanged them.

A third common problem in our practice occurs when a pharmacist substitutes one generic form of theophylline for a specific brand name of theophylline. Theophylline absorption is unpredictable and different patients metabolize different market preparations in a variety of fashions. Once a patient has suffered through the time consuming travail of theophylline medication and dosage adjustment, the substitution of another theophylline with a different absorption spectrum can lead to under-dosing or toxicity from the substituted medication.

Experiences with other drugs such as phenothiazines, digoxin, warfarin, and nitrofurantoin preparations corroborate the difficulties in patient management that have arisen from the generic substitution law. To my knowledge none has measured the cost effectiveness of this law. Has it saved the consumer money? Or has it cost the consumer more money because of failure of therapeutic response due to inadequate bioavailablity or increased toxicity due to unpredictable absorption? This is an area in which confusion reigns amidst a drought of data.

Perhaps it is time to abruptly stifle and stop this planned pattern of relentless trespass by phramacists into the practice of medicine. Physicians enjoy the legitimate training to diagnose and treat disease. Pharmacists do not. Physicians have the numbers, the resources, and the might to rebel and to stop the nonsense imposed upon us by pharmacists. Pharmacists have annoyed us and perhaps caused serious difficulties with our patients with the generic substitute law. They have tried to usurp our right to diagnostic accreditation with the recent diagnosis and treatment bill. But worse they are now causing a significant overhead expense with their sample labeling bill. It is time to expunge this additional burden from our daily hassle. It is time to wield the economic cudgels.

I propose a simple solution. Each of us who widely uses medications should dispense and sell the drugs we commonly prescribe in our practices. There are over 300 physicians in Volusia County but fewer than four dozen pharmacies. The decline in prescription business from our patients will have an adverse economic effect on pharmacies in two ways. It will deprive them of a significant portion of their medication business but, also, (and more importantly) it will reduce traffic through the pharmacy. The reduction in patient traffic flow will deprive them of sales of nonprescription items upon which there is a much higher profit margin.

Can we succeed in this strategy? Certainly. The

pharmacy law of this state grants us the privilege of writing and selling medications in our offices but we have to segregate prescription and dispensing records from the patient's chart. The paper work burden will not be too much greater than that imposed by the new law on samples. Patients will welcome the convenience of buying medications at the doctor's office without an additional trip to the pharmacy. Also, we can buy medications wholesale, sell them at a smaller mark up than that enjoyed by most pharmacies, and further elate our patients because we are providing them with cost savings on their medications. We can recover the expenses imposed upon us by the latest pharmacy law. We may even be able to turn a small profit — a profit not so large that it will ever enrich any of us but one large enough to permit us to support the family scion for a year or two at Stetson or the University of Florida or to sponsor a family trip for a couple of weeks during the winter season at Vale.

Personally I would prefer to avoid the practice of pharmacy entirely and focus on rheumatology, allergy, and clinical research. However, the pharmacists are interfering with my normal practice with the ridiculous imposition of ludicrous paper work. It is time to respond but let us respond in a fashion in which we as physicians can win in both the political and economical arenas.

Jacques Caldwell, M.D.
Economics Editor
Daytona Beach

Reprinted with permission from *The Stethoscope*, Summer 1986.

Dissent on Medicare

Health care in the U.S. is in troubled waters, not Medicare! Study a little past history.

In 1916 the AMA Board of Trustees reported to the House of Delegates that "it is better that we initiate the necessary changes rather than have them forced upon us." An AMA Committee on Social Insurance headed by Dr. Alexander Lambert reported in the same year that voluntary sickness insurance was unworkable and that only compulsory would do. In 1917 the Lambert Committee again reported favorably on compulsory insurance as did the Council on Health and Public Instruction. The House of Delegates approved the language of this council!

Dr. Morris Fishbein commented, "It seems to have been taken for granted that . . . compulsory insurance laws would be passed in the United States." Later Dr. Fishbein noted, "It is interesting to think what would have happened relating to social insurance if the war had not intervened."

The 1920 House of Delegates reversed its position. Since then the leadership of U.S. medicine has opposed Medicare; fought against Social Security for physicians, the last group to receive this support for many doctors, and in one local medical society, threatened to expel members who accepted Blue Cross-Blue Shield participation.

Do you really expect Congress, theoretically beholden to the people, to be compelled by AMA leadership and retrogressive policy and confusion?

Harry E. Beller, M.D.
Sebastian

Editor's Note: AMA has always opposed legislation, including Medicare, designed to place the federal government in complete control of the health system and to destroy free enterprise in medicine in the process. But it has also supported such measures as Kerr-Mills, Medicredit, and Eldercare, programs aimed at benefitting the elderly without the tight grip of Big Brother and with better fiscal controls. The record of Medicare speaks for itself: it is turning out to be a big flop. Medical care in the United States, despite some problems, is still the best in the world but allowing further federal intrusion into the system surely will be one step away from socialized medicine. The example of the NHI in Great Britain ought to be a big lesson for us.

More views on the drug problem

I read with great interest and admiration your two editorials in the August issue of *The Journal of the Florida Medical Association*, "Medicare in Troubled Waters" and "The Drug Problem: Tilting with Windmills." I congratulate you for your fine insight and exposition thereof.

Concerning the drug problem, I am curious as to why you think draconian laws such as those of Malaysia's are ineffective? I do not think enforcing drug tests is going to be the entire answer, although it certainly will be one of them. Immediate apprehension and harsh punishment rendered quickly (virtual impossibility in our current society) would seem to be necessary to save our country and culture.

B. L. Bercaw, M.D.
Naples

Editor's Note: Draconian laws such as those in Malaysia have not stemmed the drug problem and historically have not proved effective in curbing other

social problems. The death penalty, as a parallel example, has not done much to slow down crime rates in many countries. The solution to our drug problem may ultimately come about from a combination of stiff laws, education, and massive changes in the national attitude towards drugs. Changing our attitudes is hard, perhaps even impossible, but it holds the key to everything else.

I read with interest Dr. Lacsamana's editorial entitled "The Drug Problem: Tilting with Windmills," which appeared in the August 1986 issue of *The Journal.* I believe that our society has spent many millions of dollars on the supply side of the drug issue, meaning that much has been given to law enforcement agencies, drug regulatory agencies, etc. Even so, the flow of drugs continues to be a major problem. In our area, we are attempting to affect the demand side of the equation by educating our children from kindergarten to twelfth grade on the adverse effects of drugs. This program has received limited early funding from the Florida legislators this last session. Polk County through its Substance Abuse Committee of the School Board system has started on a trial basis an intensive program of education and peer counseling.

It is my feeling that more government dollars should be spent along education rather than enforcement. There are also a number of good lay organizations that have been addressing this problem for many years and should have the support of every physician in the state. Such an organization is known as P.R.I.D.E., which stands for Parent Resources and Information on Drug Education whose role is to educate parents of adolescent children on what drug abuse is and how to combat it.

Gordon J. Rafool, M.D.
Winter Haven

Puss caterpillars

With respect to the excellent article on the Puss Caterpillar by Doctors Rif S. El-Mallakh, Donald L. Baumgartner and Naguib Fares in the July issue of *The Journal,* I enclose a copy of my letter to the Editor of the *New England Journal of Medicine* (Vol. 271, No. 12, 1964, pg. 635), briefly reporting cases of toxic effects of the caterpillars, and a method of treatment.

To the editor: In their article on reactions to the puss caterpillar (Megalopyge opercularis), McMillan and Purcell describe equivocal response to treatment with antihistamines and analgesics. Large numbers of these caterpillars are found in the area of Miami, Florida, during the spring and summer, and we have had occasion to evaluate various methods of treatment of the toxic effects of contact with them. We have found, as have others, that antihistamines and adrenal corticosteroids have been of little help. Atropine has seemed to be a specific remedy. The local effects of contact with caterpillars are usually aborted by local application of an atropine-containing ophthalmic ointment. In patients in whom treatment is delayed or who have evidence of systemic toxicity, parenteral atropine usually gives prompt relief.

Ralph Slonim, M.D.
Miami

FAMILY PRACTICE. A REWARDING EXPERIENCE IN ARMY MEDICINE.



THE ARMY RESERVE IN THE SOUTHEAST NEEDS PHYSICIANS WHO SPECIALIZE IN FAMILY PRACTICE, TO JOIN AN EXCEPTIONAL TEAM.

WE UNDERSTAND THE DEMANDS ON A BUSY PRACTITIONER. SO WE'RE FLEXIBLE ABOUT TIME, PARTICULARLY WHEN IT'S TIME YOU WANT TO SHARE WITH YOUR COUNTRY.

IN THE ARMY RESERVE, YOU'LL FIND OPPORTUNITIES THAT ARE CHALLENGING AND VARIED. OPPORTUNITIES TO PARTICIPATE IN EXCITING TRAINING PROGRAMS AND WORK WITH OUTSTANDING PHYSICIANS FROM EVERY AREA OF THE COUNTRY AND TO EXTEND ASPECTS OF YOUR SPECIALITY. WE THINK A FIRST PHONE CALL COULD PROVE TO BE REWARDING.

THE ACTIVE ARMY HAS MORE SOLDIERS WITH FAMILIES THAN EVER BEFORE. SO WHEN YOU JOIN THE ARMY MEDICAL TEAM AS A FAMILY PRACTITIONER, EXPECT TO SPEND MOST OF YOUR TIME SERVING NOT ONLY SOLDIERS, BUT THEIR SPOUSES AND CHILDREN, TOO. WHAT'S MORE, YOU WON'T HAVE TO WORRY ABOUT THE PAPERWORK, MALPRACTICE INSURANCE PREMIUMS, OR THE COSTS INCURRED IN RUNNING A PRIVATE PRACTICE.

WORKING WITH A TEAM OF HIGHLY TRAINED PROFESSIONALS, YOU CAN RECEIVE ASSIGNMENTS ALMOST ANYWHERE IN THE U.S. AS WELL AS OVERSEAS. PLUS UP TO 30 DAYS OF PAID VACATION AND REASONABLE WORK HOURS.

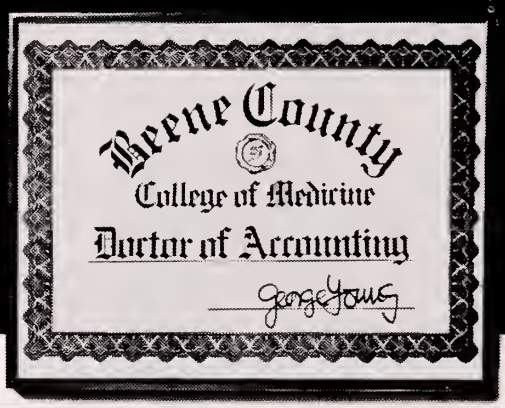
ALL IN ALL, YOUR ARMY FAMILY PRACTICE WILL BE A REWARDING EXPERIENCE.

TALK TO YOUR LOCAL U.S. ARMY OR ARMY RESERVE MEDICAL DEPARTMENT COUNSELOR FOR MORE INFORMATION ON FAMILY PRACTICE IN THE ARMY.

ARMY/ARMY RESERVE MEDICINE
3101 MAGUIRE BLVD
ESSEX BLD, SUITE 166
ORLANDO, FL 32803
CALL COLLECT: (305) 896-0780

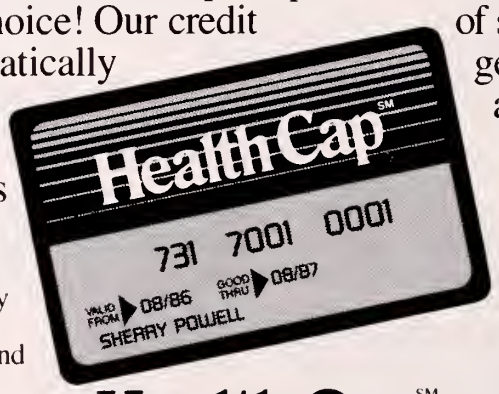
ARMY. ARMY RESERVE. BE ALL YOU CAN BE.

Your money or your life!



You can continue moonlighting as an accountant — involved in monthly billing, collections and credit problems — or spend your life as intended: practicing medicine! Health Cap's[SM] the hands-down choice! Our credit card system automatically deposits your fees in full, up front, on the day services are rendered.

And with a separate line of credit used only for health care, your patients can afford – without hardship – regular preventive treatment and elective procedures. Were all those years of study and dedication geared to chasing down accounts receivable? With Health Cap, your life is much more rewarding!



C&S ® Brought to you by Health Care Assistance Corporation and C&S National Bank.

Get more information today! Call toll-free in Florida: 1-800-282-5599; out of state: (813) 885-6584.

Health Cap[SM]

The credit card for your medical and financial well-being.

8316 Hanley Road, Tampa, FL 33614

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
OCTOBER 1986, Vol. 73, No. 10

Update on contraception

In its landmark monograph, "Making Choices — Evaluating the Health Risks and Benefits of Birth Control Methods," the Alan Guttmacher Institute reports an astonishing fact — more than half of all pregnancies in the United States are unintended, either unplanned or unwanted. Here are the statistics: among 55 million U.S. women of reproductive age, 36 million are faced with the problem of unintended pregnancy. Although nine out of ten use some type of contraceptive method — most commonly sterilization or the pill — 3.3 million have an unintended pregnancy every year. This represents over 50% of the six million total pregnancies annually in the U.S. These are disturbing statistics considering the aftermath of unintended pregnancy: approximately one million abortions and nearly one million unplanned pregnancies annually among teenagers. On a per capita basis the teen pregnancy rate in the U.S. is one of the highest among Western industrialized nations.

What accounts for these facts? Numerous reasons have been advanced for the wide gap between Americans' contraceptive intent and their actual practices — from ambivalence about sex to lack of access to health care. But the Guttmacher report adds one more — perhaps the most important — reason: "The considerable fear, doubt and confusion with which many American women and their partners confront their contraceptive choices." In recognition of this theme, Luella Klein, the first woman president of the American College of Obstetricians and Gynecologists in 1984, made the unintended pregnancy problem her number one priority. And in her presidential address "To Have or Not To Have a Pregnancy," she urged physicians "to provide clear, unambiguous statements to our patients based on scientific and epidemiologic data of the risk and benefits of contraceptive methods comparable with the risks of pregnancy and other everyday activities."

The purpose of this series on contraception is to facilitate that process by providing the kind of balanced information that we as practitioners can use in counseling and prescribing for our patients. In an era of shrinking federal funding for contraceptive programs, the need for physicians to speak out and to educate both their patients and the public has never been greater.

"Update on Contraception" represents a collaborative effort by members of the recently formed Tampa OB-GYN Society whom I wish to thank for volunteering their time and making this project possible. Robert E. McCammon, M.D., starts out with a review of the teen pregnancy issue and how attitudes among various groups including the media have impacted on this national problem. An overview of oral contraceptives by Bruce D. Shephard, M.D., provides a historical perspective on the pill's evolution over the past 26 years, toward increasingly safer and more sophisticated products. J. Kell Williams, M.D., carries the discussion further by looking at how newer low dose pills have been found to minimize effects on lipid and carbohydrate metabolism. The main alternatives to the pill — the various barrier and rhythm methods of contraception — are then discussed in detail by Michael S. Fernandez, M.D. Finally the series concludes with a discussion by Robert Yelverton, M.D., concerning medical-legal aspects of contraceptive practice including the product liability issue. We hope this review of contraception in 1986 will better enable practitioners to help their patients make rational, realistic choices about birth control.

Bruce D. Shephard, M.D.
Tampa

Unintended pregnancy — a U.S. problem

Robert E. McCammon, M.D., F.A.C.O.G.

ABSTRACT: This paper reviews the scope of unintended pregnancy, a problem which has become an epidemic in the United States. Unplanned teen pregnancy, a central part of this epidemic, is also at the very hub of the U.S. poverty cycle. Political, social and educational aspects of unintended pregnancy are discussed.

The Author
ROBERT E. McCAMMON, M.D., F.A.C.O.G.
Dr. McCammon is Associate Clinical Professor of Obstetrics-Gynecology, University of South Florida College of Medicine, Tampa.

Unplanned pregnancies constitute an epidemic in the United States, an epidemic that is largely preventable. Each year, over three million unplanned pregnancies occur, and over 1.5 million induced abortions are performed. Women of minority races and those with fewer than 12 years of education are at the highest risk of having unwanted children.[1] "Children Having Children" is how *Time* headlined its cover story in December 1985.[2] More than a million American teenagers will become pregnant each year, four out five of them unmarried. Florida statistics are hard to find, but in 1984 there were 39,318 births to unwed mothers, 25% of whom were under 19 years of age.

Teenage pregnancy has been around as long as there have been teenagers, but its pervasiveness in this country, the dimensions of its social costs, and the urgent need to attack the problem are just beginning to be appreciated. Teenage childbearing cost the nation $16.6 billion last year, and the 385,000 children who were the firstborn of adolescents in 1985 will receive $6 billion in welfare benefits during the next 20 years. According to the Non-Profit Center for Population Options[3] in Washington, D.C., this figure is up from $8.55 billion in 1975. The report goes on to say that a third of the welfare total, $2.4 billion, could have been saved had teenage mothers waited until they reached age 20 to have their first baby. We are all familiar with the problems of lack of prenatal care by teenagers and unwed mothers. Thus most of these pregnancies are high risk and their complication rate is much greater. Prevention of unintended birth is clearly cost effective.

Adolescent pregnancy • As infants, the offspring of teen mothers have a high rate of illness and mortality; later in life they often have educational and



(AUDIO: VIDEO COMPUTER SOUNDS)



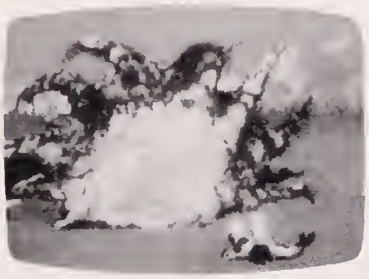
...



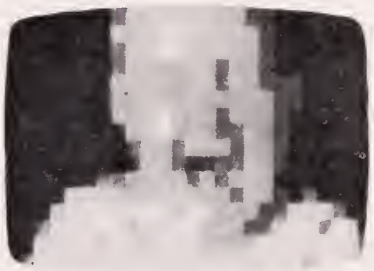
...



(VIDEO GAME NOISE STOPS SUDDENLY)



(EXPLOSION)
ANNCR VO: Don't let the game...



(Dissolve into animated baby.)
(BABY CRIES)
of life...



beat you.



Get the facts on the many ways...



to prevent unintended pregnancies.



The American College of Obstetricians and Gynecologists...



wants you to have the FACTS.



For your free FACTS booklet, call 1-800-INTENDS. 1-800-INTENDS.

Fig. 1. — The American College of Obstetricians and Gynecologists public service announcement to reduce unintended pregnancies.

emotional problems. Many of these children of children are prone to drop out of school and become teenage parents themselves. With disadvantage creating disadvantage, it is no wonder that adolescent pregnancy is widely viewed as the very hub of the U.S. poverty cycle.

A multinational comparative study of teenage sexual practices by the Alan Guttmacher Institute[4] recently showed that the U.S. leads nearly all other industrialized countries in rates of teenage pregnancy, abortion, and childbearing. In fact, we are the only country in which the teenage pregnancy rate has been increasing in recent years. The pregnancy rate for American adolescents aged 15-19 is 96 per 1,000 compared with 14 per 1,000 in the Netherlands, 35 in Sweden, 43 in France, 44 in Canada, and 45 in England. The study's findings ran counter to many widely held views including the belief that liberalized attitudes toward sex lead to more teenage pregnancy. In fact, the researchers said, countries with the most liberal attitudes, readily available contraceptive services for adolescents, and widespread sex education programs had the lowest rates of teen pregnancy, abortion, and childbearing. The study also showed that the levels of teenage sexual activity in the U.S. are not very much different from those in other countries with much lower teen pregnancy rates. Pregnancy rates are higher among black than white U.S. adolescents; however, the rate of pregnancy among white teens in the U.S. is much higher than in other countries.

If one examines the problem in the U.S., he finds that there is no well-defined expression of political will in the U.S. on this issue. The political and religious leaders are divided over whether their primary mission should be to eradicate or discourage sexual activity among young people or to help reduce teenage pregnancy by promoting sex education and contraceptive use. It is a complex problem, one that strikes many sensitive nerves, for the subject of adolescent sexuality is one that makes many Americans squirm. It seems to raise almost every politically explosive issue facing the American public. In the meantime, while our teens are confused by the adults' division over what should be done, they are constantly exposed to sex in their music, TV, movies, radio, and rock idols.

Encouraging starts ● What is being done in the U.S.? Obviously not a great deal, but there are some encouraging starts here and there. Education is of fundamental importance. The American College of Obstetricians and Gynecologists has started a major media program to promote the safety and effectiveness of family planning and is providing more information to its members. Last year the ACOG unveiled a new public service announcement (Fig. 1) designed to combat teen pregnancy. All three major TV networks balked at showing it. The reason: the announcement included the word "contraception." The word was dropped and the announcement has been run, but these are the same networks that are filled with fairly explicit sex and violence and that routinely use sex to sell many products. The state of Wisconsin last year passed a law that, among other things, provides for funding of sex education in public schools. The school board in Los Angeles has plans to open a health clinic offering contraception to high school students, but of schools across the U.S. have done this.

A *Time* poll[2] showed that 78% of Americans favor sex education in the schools; yet the subject remains a divisive one. Private enterprise, charities, religious groups, schools, and local governments must start doing something soon about this problem. American women cannot and will not enjoy the full measure of citizenship until they can control their fertility and, hence, be able to control their lives.[1] We as physicians, whatever our personal views, must start assuming a leadership role as have physicians in other industrialized countries to educate our patients and the public on sex education, responsibility, and contraception. We must find a way to help the teenagers obtain better prenatal care in order to reduce the complications of pregnancy, prematurity, and the endless cycles of poverty, child abuse, and later life problems that so frequently follow.

References

1. Grimes, D.A.: Obstetrics Gynecology 67:438, 1986.
2. Time, December 9, 1985.
3. The New York Times, February 20, 1986.
4. The Alan Guttmacher Institute: Teenage Pregnancy in Developed Countries: Determinants and Policy Implications. Fam. Plann. Perspect. 17(2):53-63, 1985.

● Dr. McCammon, Associate Clinical Professor, Department of Obstetrics-Gynecology, University of South Florida College of Medicine, 829 W. Buffalo, Tampa 33603.

Oral contraceptives — an overview

Bruce D. Shephard, M.D., F.A.C.O.G.

Oral contraceptives first became available in the United States in 1960. Since then a tremendous amount of information has been gathered about the "pill," the most effective and most popular reversible method of birth control available. To date, 150 million women worldwide — including forty million in the U.S. — have used the pill at some point in their lives. In 1982, ten million American women were on the pill.

During its more than twenty-five year history, the pill has been the subject of intense medical research, becoming the most studied drug in America. Because of its public health importance and impact on millions of women, the pill has received close scrutiny by the press. At times media reports have focused on negative or sensational aspects, but when seen in perspective, the pill's evolution has been a steady rational progression toward increasingly improved products. Greater safety and increased public confidence in oral contraceptives have resulted substantially from three factors: the availability of lower dose pills, a better identification of risk factors, and increased public awareness of non-contraceptive health benefits associated with pill use.

The pill in perspective — a history of decreasing dosage • The pill of the 1980's has changed significantly from what it was over a quarter century ago. The combination pill, used by 99% of women using oral contraceptives, still contains the same two hormones — estrogen and progesterone in synthetic form — but the dosages and formulations have changed giving the new pill a wider margin of safety. Present day birth control pills contain one-fifth the estrogen and one-tenth the progesterone as in the original pills.

The Author
BRUCE D. SHEPHARD, M.D., F.A.C.O.G.
Dr. Shephard practices Obstetrics and Gynecology in Tampa and is a Clinical Associate Professor of Obstetrics and Gynecology at the University of South Florida College of Medicine.

When introduced in 1960 there was an initial rush of optimism among consumers and health professionals alike. The pill appeared to have all the elements of an ideal method of birth control — effectiveness, safety, and convenience. One of the first hints of trouble came from England in 1967 when The Royal College of General Practitioners reported on the development of blood clots in some healthy young women taking the pill. Other large studies in the late 1960's in both the United States and Great Britain confirmed an increased risk of venous thrombosis in pill users. These studies identified a direct relationship between the estrogen dosage and the risk of blood clots. During the early 1970's lowered estrogen dosage became the hallmark of a second generation of birth control pills containing from 50 to 80 micrograms of estrogen — pills which were half as likely to precipitate venous thrombosis as the original formulations which contained 100 to 150 micrograms.

Another attempt to prevent side effects — which in the 1970's were attributed almost entirely to the estrogen component — was the introduction of the mini pill in 1973. The mini pill, which contained only progesterone, has proved to have a number of disadvantages compared to the two hormone combination pill. The mini pill has a higher pregnancy rate — 3% compared to less than 1% for the combination pill — and a rather high frequency of side effects, especially breakthrough bleeding. The mini pill is used by approximately 1% of pill users in the United States today.

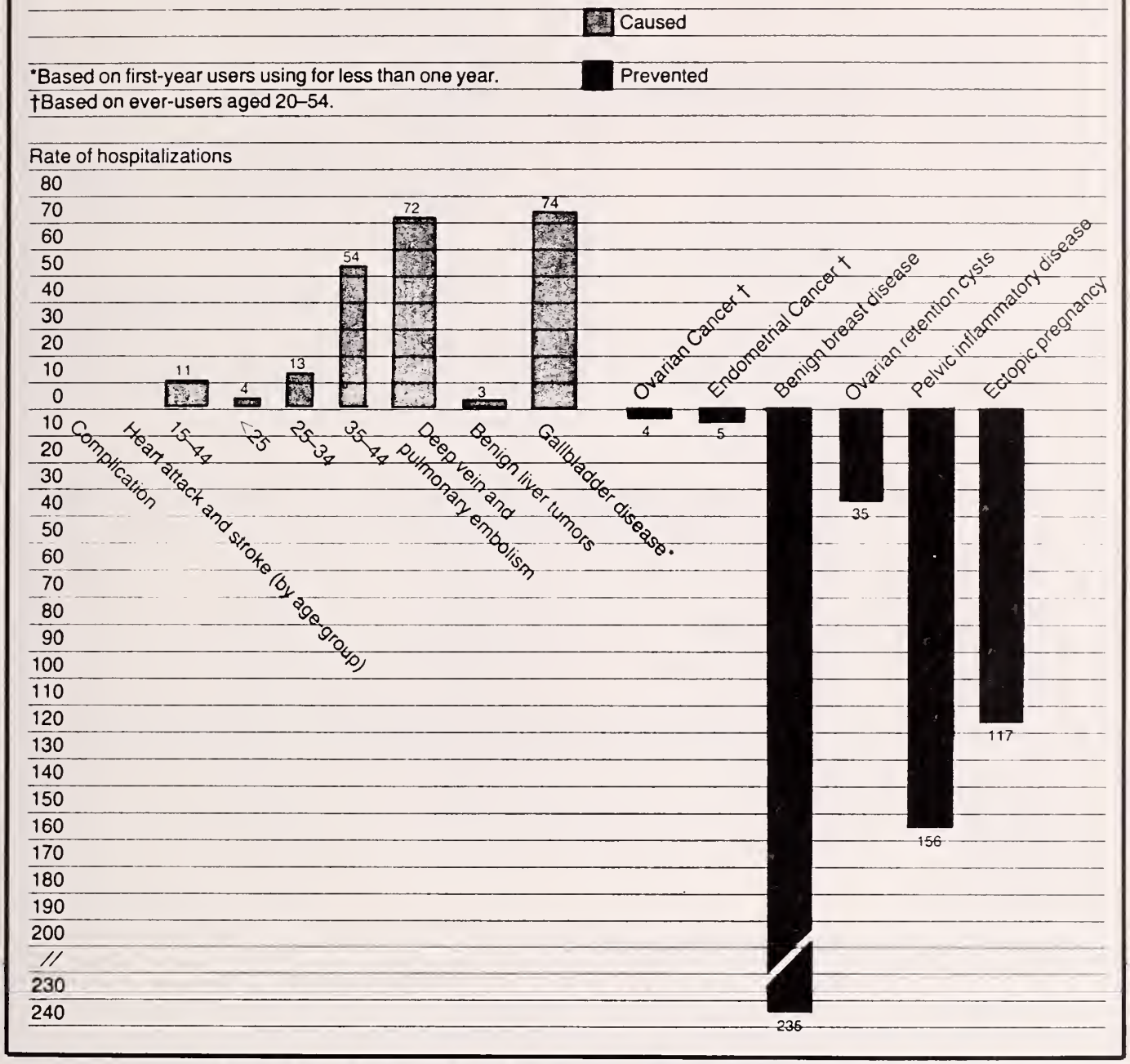
In 1975, a third generation of combination pills with still lower amounts of estrogen — containing from 30 to 35 micrograms — was introduced in an attempt to further enhance safety. The "sub-50's" or low dose pills as this group became known, soon gained widespread popularity as safety was maximized without loss of effectiveness. The benefits to be derived from decreased estrogen dosage were clearly indicated by a fall in the rate of venous thrombosis from 40 per 100,000 users in 1965 to less than 10 per 100,000 users per year by 1978. A second advantage to lowered estrogen dosage was that some less serious side effects such as nausea and breast tenderness were also reduced although the new formulations did result in slightly higher rates of breakthrough bleeding. By 1980 more than half of all pills prescribed contained less than 50 micrograms of estrogen. By 1985, low dose pills were being used by 65% of all women using oral contraceptives in the United States. In that same year the Canadian government took a significant step of its own by recommending through its Health and Welfare Department the use of low dose pills for all Canadian women using oral contraceptives. As more patients and physicians become aware of the greater safety of low dose pills, the use of these formulations, in preference to those of higher dosage, can be expected to increase in the U.S.

During the 1980's, with estrogen dosage as low as therapeutically possible, medical research on the pill has shifted toward a more thorough evaluation of the progesterone component. As early as 1974, the Royal College of General Practitioners study found a correlation between progesterone dosage and the frequency of high blood pressure developing in pill users. Subsequent studies found that high blood pressure, which was likely to develop in about 5% of pill users on higher dose pills, will revert to normal when the pill is stopped. Additional research has also linked pills containing progesterone in high dosages to elevations in blood sugar and blood cholesterol. Newer studies are presently underway to determine if pills containing lower dosages of progesterone will also show these or any other potentially adverse metabolic effects. Since progesterone dosage has declined from 10 milligrams in the original pill to one milligram or less in present day formulations, there appears to be a wide margin of safety for most healthy young women using oral contraceptives.

In the mid-1980's, further research on the pill has become more fine tuned with greater emphasis on how different types and combinations of hormones influence side effects and safety. The most recent development in this area has been the introduction of a new formulation of pills known as "multiphasics" or sometimes as "triphasics." Multiphasic pills are basically low dose pills which for the first time vary hormone dosage in each of three separate phases in an attempt to roughly simulate changes that would occur in a normal menstrual cycle. All but one of the multiphasic pills vary just the progesterone dosage while one varies the dosage of estrogen as well as the progesterone. Multiphasic pills also reduce overall dosage somewhat making multiphasics an attractive alternative among low dose pills.

Risk factors — knowing who should not take the pill • A better understanding of risk factors — knowing which women are least and which are most likely to experience serious side effects — has dramatically increased the margin of safety for women considering taking the pill. In their landmark monograph, "Making Choices," the Alan Guttmacher Institute, Table 1, has published one of the most comprehensive reviews of birth control pill risks and benefits to date. The report revealed that if women over 35 or who smoked cigarettes did not take the pill, 86% of the approximately 500 pill-related deaths that occur each year could be prevented. Smoking rather than age (over 35) has been considered the single most important risk factor associated with pill use. If women having other cardiovascular risk factors such as high blood pressure, or diabetes were to avoid the pill, the risk of cardiovascular complications such as blood clots and heart disease could be reduced even further.

Table 1. — Estimated Annual Rate of Hospitalizations Attributed To And Prevented By Use Of Oral Contraceptives Per 100,000 Pill Users. Reprinted from "Making Choices — Evaluating the Health Risks and Benefits of Birth Control Methods," The Alan Guttmacher Institute.



The identification of women at risk for pill complications has allowed young healthy non-smoking women to take birth control pills with more confidence than previously. In fact the risk of death among non-smoking women taking the pill is no more than for women using less effective methods of birth control when the medical risks of pregnancy are considered. Compared with pregnancy, the pill is at least five times less likely to cause death. Table 2 lists absolute contraindications listed in package inserts with one addition: age 35 or more and smoking over 15 cigarettes a day — a combination of risks considered by most physicians as the single greatest cause of serious complications among women using birth control pills. Table 3 indicates relative contraindications to the pill — factors which mean a woman is at an increased risk for serious side effects especially if two or more factors are present. Table 4 indicates the possible side effects of using the pill. Table 5 is a comparison of combination birth control pills by dosage.

Non-contraceptive health benefits of the pill • The identification of a number of health benefits associated with taking birth control pills has increased public confidence in oral contraceptives in recent years. The Guttmacher Report has attempted

Table 2. — Absolute Contraindications to Birth Control Pills.

1. Present or previous thromboembolic disease including coronary artery disease.
2. Present active liver disease such as hepatitis or cirrhosis.
3. Present or previous cancer of the breast or endometrium.
4. Pregnancy — known or suspected.
5. Abnormal or unexplained vaginal bleeding.
6. Age 35 or more and smoking 15 cigarettes or more per day.

Table 3. — Relative Contraindications to Birth Control Pills.

migraine headaches
*diabetes (requiring insulin)
*high blood pressure
depression
gallbladder disease
liver disease
*family history of heart attacks before age 50
family history of breast cancer
jaundice during pregnancy
*high blood pressure or diabetes that develops during pregnancy
*over age 40
*history of cigarette smoking
*elevated blood lipids (cholesterol, triglycerides)

*cardiovascular risk factors

Table 4. — Possible Side Effects of Birth Control Pills

Mild Side Effects (usually subside in three months)

Nausea (most common)
Weight gain (usually less than five pounds)
Fluid retention
Spotting between periods (breakthrough bleeding)
Breast tenderness

Moderately Serious Side Effects (consider switching to lower dose pill or advising alternate contraceptive method)

Breast pain, discharge, or engorgement
Reduced tolerance to contact lenses
Amenorrhea
Headaches (may be migraine or related to high blood pressure)
Nervousness
Depression
Decreased libido

Serious Side Effects — Danger Signals (indications to stop pill)

Symptom	Possible Cause
Leg tenderness	Thrombophlebitis
Sudden chest pain, shortness of breath	Pulmonary embolus or coronary throbosis
Sudden weakness, numbness, or inability to move a part of the body; impaired speech, blurred vision, blackouts	Stroke
Sudden, partial or complete loss of vision	Retinal thrombosis
Jaundice	Liver disease

Potential Beneficial Effects of Birth Control Pills

Shorter, more regular menstrual periods
Decreased menstrual pain
Less premenstrual tension
Fewer breast cysts
Decreased endometriosis
Decreased rheumatoid arthritis (slight effect)
Less ovarian cancer and fewer ovarian cysts
Less uterine cancer
Less pelvic inflammatory disease

Table 5. — Comparison of Combination Birth Control Pills by Dosage

	Brand Name	Estrogen	Estrogen Dose (Micrograms)	Progesterone	Progesterone Dose (Milligrams)
Group I, High Dose (greater than 50 micrograms of estrogen)	Enovid E	Mestranol	100	Norethynodrel	2.5
	Enovid 5	Mestranol	75	Norethynodrel	5
	Norinyl 1/80	Mestranol	80	Norethindrone	1
	Norinyl 2	Mestranol	100	Norethindrone	2
	Ortho-Novum 1/80	Mestranol	80	Norethindrone	1
	Ortho-Novum 2	Mestranol	100	Norethindrone	2
	Ovulen	Mestranol	100	Ethynodiol diacetate	1
Group II, Medium (50 micrograms of estrogen)	Demulen 1/50	Ethinyl estradiol	50	Ethynodiol diacetate	1
	Norinyl 1/50	Mestranol	50	Norethindrone	1
	Norlestrin 1/50	Ethinyl estradiol	50	Norethindrone acetate	1
	Norlestrin 2.5	Ethinyl estradiol	50	Norethindrone acetate	2.5
	Ortho-Novum 1/50	Mestranol	50	Norethindrone	1
	Ovcon 50	Ethinyl estradiol	50	Norethindrone	1
	Ovral	Ethinyl estradiol	50	Norgestrel	.5
Group III, Low Dose (less than 50 micrograms of estrogen)	Brevicon	Ethinyl estradiol	35	Norethindrone	.5
	Demulen 1/35	Ethinyl estradiol	35	Ethynodiol diacetate	1
	Levlen	Ethinyl estradiol	30	Levonorgestrel**	.15
	Loestrin 1/20	Ethinyl estradiol	20	Norethindrone acetate	1
	Loestrin 1.5/30	Ethinyl estradiol	30	Norethindrone acetate	1.5
	LoOvral	Ethinyl estradiol	30	Norgestrel	.3
	Modicon	Ethinyl estradiol	35	Norethindrone	.5
	Nordette	Ethinyl estradiol	30	Levonorgestrel**	.15
	Norinyl 1/35	Ethinyl estradiol	35	Norethindrone	1
	Ortho-Novum 1/35	Ethinyl estradiol	35	Norethindrone	1
	Ortho-Novum 10/11*	Ethinyl estradiol	35	Norethindrone	(.5-1)
	Ortho-Novum 7/7/7*	Ethinyl estradiol	35	Norethindrone	(.5-1)
	Ovcon 35	Ethinyl estradiol	35	Norethindrone	.4
	Tri-Levlen*	Ethinyl estradiol	30-40	Levonorgestrel**	(.05-.125)
	Tri-Norinyl*	Ethinyl estradiol	35	Norethindrone	(.5-1)
	Triphasil*	Ethinyl estradiol	30-40	Levonorgestrel**	(.05-.125)

*"Multiphasic" pills
**The active form of norgestrel

to quantify health benefits and risks to provide a more accurate overall picture of pill effects. As seen in Table 1, many more hospitalizations are prevented than are caused by the pill. About 58,000 hospitalizations per year are prevented in pill users and about 9,000 hospitalizations — mostly for blood clots — are attributed to pill use annually among 10 million women. Among hospitalizations prevented, most were for benign breast disease, pelvic inflammatory disease, ectopic pregnancy, ovarian cysts, ovarian cancer, and endometrial cancer. It is estimated that 1,700 cases of ovarian cancer — including 850 deaths from this disease — are prevented each year among pill users.

A number of medical benefits associated with the pill use can be explained by the pill's effects on the female reproductive system. Ovulation suppression, for example, is probably the mechanism responsible for reducing the numbers of ovarian cancers, ovarian cysts, painful periods, and premenstrual syndrome in pill users. The continuous presence of progesterone in oral contraceptives provides another mechanism conferring health benefits. The anti-estrogen effect of progesterone prevents target organs such as the uterus and breast from receiving strong unopposed estrogen stimulation as would occur in a normal menstrual cycle. The protective effect of progesterone is an important factor in the 50% reduction in endometrial cancer and in the prevention of thousands of cases of benign breast disease — breast cysts, fibrocystic breast disease and benign solid tumors — annually in pill users. Because of the anti-estrogen effect on the uterine lining, pill users experience shorter, lighter menstrual periods and have less iron deficiency anemia compared to non-users.

Special concerns and long term effects of the pill — the pill and pregnancy • Several studies have indicated a slight risk of birth defects in women taking the pill during the first three months of pregnancy. However no evidence has linked birth defects or miscarriages to pregnancies conceived immediately after going off the pill. Previously women were urged to wait six months after going off the pill before attempting pregnancy. This wait is now known to be unnecessary. A wait of one to two months is advised to allow ovulation and a normal menstrual cycle to occur. This is because once a menstrual cycle becomes established after stopping the pill, calculation of the due date if pregnancy should occur becomes much more reliable.

The pill and infertility • The overall fertility of pill-users and non-users is identical regardless of how long a woman is on oral contraceptives. In the first cycle after the pill is stopped, ovulation is sometimes delayed a few weeks but overall capacity for becoming pregnant is unchanged. Women who have had infrequent periods prior to pill use are more likely to experience post-pill amenorrhea. The problem is usually corrected by inducing ovulation if pregnancy is desired. Ovulation delay affects fewer than 1% of women using the pill. Since pill users have a decreased risk for pelvic inflammatory disease and for ectopic pregnancy, use of oral contraceptives may protect against future infertility in some women.

Educating the public • Although oral contraceptives have evolved toward increasingly more sophisticated and safer products, pill popularity has declined in recent years. In 1973, while 36% of married women using contraception selected the pill, only 20% did in 1982. The sheer volume of reports in the media — many of them adverse — have shaken public confidence in the pill. A lack of consistent health education programs in the public schools has in some instances contributed to misinformation about the pill and other birth control methods. A Gallup Poll in 1985 revealed, for example, that about 75% of U.S. women believe that "pill use carries substantial health risks." Yet the Guttmacher Report found that the pill is estimated to prevent at least five times as many hospitalizations as it causes.

The general public has not yet begun to take full advantage of new information affecting the decision to use birth control pills or other contraceptives. For example, some sexually active women with known risk factors still elect to use oral contraceptives when safer methods of birth control are available. Other women without risk factors sometimes avoid the pill because of misconceptions about it and choose a method far less likely to prevent pregnancy. Despite the recognized greater safety of modern low dose formulations, over 3.5 million women in the United States were receiving pills containing 50 micrograms of estrogen or higher in 1985. More education is needed, both in the schools and through the media, to make contraceptive decision-making a more rational process. Such education should emphasize potential risks as well as benefits of oral contraceptives and the importance of low dose formulations whenever this contraceptive alternative is selected.

References

1. Dickey, R.P.: Managing Contraceptives Pill Patients, ed 4. Durant Okla, Creative Informatics, Inc., p 43.
2. Dorflinger, L.J.: Relative potency of progestins used in oral contraceptives. Contraception 1985, 31:565.
3. Gallup Organization, Inc.: Attitudes Toward Contraception, Washington, D.C., The American College of Obstetricians and Gynecologists, March 1985.
4. Grimes, D.A.: Can Oral Contraceptives Counter Cancer? Dialogues in Contraception 1985, 2:1.
5. Hatcher, R.A.; Stewart, F.; Stewart, G.K., et al: Contraceptive Technology 1986-1987, ed 13. New York, Irvington Publishers Inc., p 153.
6. Inman, W.H.; Vessey, M.P.; Westerholm, B., et al: Thromboembolic Disease and the Steroidal Content of Oral Contraceptives: A Report to the Committee on Safety of Drugs, Brit. Med. J. 1970, 2:203-209.
7. Kay, C.R.: Progestogens and Arterial Disease — Evidence from the Royal College of General Practitioner's Study, AM. J. Obstet. Gynecol., 1982, 142(6, pt 2):762-765.
8. Lipid Research Clinics Program: The Lipid Research Clinics Primary Prevention Trial Results. II. The Relationship of Reduction in Incidence of Coronary Heart Disease to Cholesterol Lowering, JAMA 1984, 251:365-374.
9. Mishell, D.R. (ed): Dialogues in Contraception (special report), 1985.
10. National Institutes of Health Consensus Conference: Lowering Blood Cholesterol to Prevent Heart Disease, JAMA 1985, 253:2080-2086.
11. Ory, H.W.; Forrest, J.D.; Lincoln, R.: Making Choices — Evaluating the Health Risks and Benefits of Birth Control Methods, New York, The Alan Guttmacher Institute, 1983.
12. Spellacy, W.N.: Metabolic Effects of Oral Contraceptives, Dialogues in Contraception 1985, 1:17.
13. Speroff, L.; Grimes, D.A.; Mishell, D.R., et al: Prescribing OCs For Safety, Contemp. OB/GYN 1986, 27:128-148.

Reprinted with permission from *Encyclopaedia Britannica's Health Annual*, November 1986.

• Dr. Shephard, 2901 Isabel Street, Suite B., Tampa 33607.

Oral contraceptives — the long-term perspective

J. Kell Williams, M.D., F.A.C.O.G.

It is estimated that 50-60 million women worldwide now use oral contraceptive pills as their means of birth control. Even though the pill remains the most common method of reversible contraception, there has been a significant decrease in usage by American women since the mid-1970s. An important cause of this decline is fear generated by the lay press regarding long term effects. This attitude was noted in a recent Gallup poll of the general population regarding oral contraceptives. Among other findings, 76% of responders believed that the "pill" created a serious health risk and 31% believed that it caused cancer.

The medical community, too, has received the pill at times with confusion or skepticism. Considering the myriad of oral contraceptive articles in the medical literature over the last 25 years, it is also obvious that there are data to support any of one's personal and professional biases. Yet the history of the "pill" is one of decreasing dosages of steroid hormones to a point where the effects of the original formulation are not comparable to the current low-dose pill. The concerns which have received the most attention from medical researchers — the metabolic effects and any potential input on neoplasia — will be addressed in this article.

Carbohydrate metabolism • Glucose tolerance is initially diminished in a significant number of women taking oral contraceptives. This may be more pronounced in women predisposed to diabetes such as the gestational diabetic.[1] Early studies showed an overall risk of glucose intolerance of 44% in women who were gestational diabetics and placed on oral contraceptives containing 50 mcg of estrogen and 1 mg of progestin.[2] In contrast, a recent report from Denmark showed no alteration in glucose metabolism in women with a history of glucose intolerance during pregnancy now taking a low-dose triphasic pill.[3] The lowering of glucose tolerance in these predisposed patients may bring the prediabetic to insulin dependence sooner, thereby giving the individual a longer exposure to the atherogenic effect of the diabetes. Overt, insulin-dependent diabetics will usually have only a slight change in glucose metabolism and will have a small increase in insulin requirement, making diabetes only a relative contraindication to the pill. The changes are related to the progestin. Estrogens have been found to have either no effect or a slight beneficial effect on carbohydrate metabolism. In one study, a low-dose norethindrone-containing pill had no adverse effect on glucose tolerance in contrast to norgestrel.[4]

Lipid metabolism • Numerous reports on the metabolic effects of oral contraceptives suggest that alteration of the serum lipoprotein pattern brought about by synthetic steroids may increase the risk of cardiovascular disease. The role of high-density-liproproteins (HDL) and low-density-lipoproteins (LDL) in this risk assessment has created considerable interest. Based on the "lipid hypothesis", a simplistic approach that states that LDL increases the risk of heart disease and HDL (especially HDL_2) decreases the risk, the effect of contraceptive steroids on these lipoproteins becomes important.[5] The hypothesis also suggests that small changes in lipid status result in significant changes in cardiovascular risk — for any

The Author
J. KELL WILLIAMS, M.D., F.A.C.O.G.
Dr. Williams is Assistant Professor of Obstetrics and Gynecology at the University of South Florida College of Medicine, Tampa.

decrease in LDL cholesterol there is a two-fold decrease in the risk of cardiovascular disease. Admittedly, the hypothesis does not suggest a mechanism to explain these results.

Early studies showed that ethinyl estradiol (20-50 mcg) significantly increased HDL, while norethindrone (5 mg) lowered HDL.[6] Theoretically, the combination of the two would result in no clinically significant change in the lipid profile. There is evidence that all progestins are not equal when considering potency and lipid effect. The more androgenic the progestin, with norgestrel being the most androgenic and norethindrone being the least, the greater the adverse effect on HDL and LDL. However, significant difficulty arises when discussing progestin potency. Standard determinations of potency have been based on delay of menses tests or the effect on the rat endometrium, neither of which may have relevance to human disease.

Coronary artery disease • In 1970 the first report of an association between oral contraceptive usage with coronary artery disease was published.[7] The risk was estimated to be 2.8 times for the 30-39 age group and 4.7 times for the 40-44 age group. In 1976 the same authors reduced the estimated risk to the 40-44 age group to 2.8, equal to the 30-39 age group.[8] In a companion study, where it was possible to evaluate additional risk factors, an increased incidence was found only if pill use was combined with one or more of the following factors: hypertension, hyperlipoproteinemia, cigarette smoking, obesity or diabetes.[9] When cigarette smoking was separated as a distinct risk factor, it was found that nonsmoking oral contraceptive users had a 1.8 times increased risk of myocardial infarction as compared with an estimated 4.8 times risk for users who smoke and that it was possible that chance accounted for the increase risk attributable solely to oral contaceptives.[10]

Jick et al concluded that acute myocardial infarction in otherwise healthy, premenopausal women is almost exclusively an illness of cigarette smokers.[11] The Walnut Creek Study found an increased incidence of myocardial infarction with oral contraceptive usage only in smokers over age 40.[12] A recent study has related any increase in risk to the progestin component independent of the estrogen component.[13]

Thromboembolic disease • The first untoward complication of oral contraceptive usage to be statistically established was that of thrombophlebitis and thromboembolism.[14] Early reports found the risk to be increased seven times with pill usage and positively correlated with age. In 1981 the Walnut Creek Study contradicted the British reports and found no significant increase in thromboembolism in a comparison of current users, past users and never users. In spite of acknowledged weaknesses in this study, it suggests that in a relatively healthy population, the risk, if present, is small.[12] Many studies have been able to directly correlate the risk of thromboembolism to steroid dose and demonstrate that the decreasing incidence of this complication has mirrored the declining dose of steroids in oral contraceptives, most likely the estrogen component, over the last 15 years.

Hypertension • Hypertension has been reported to develop in approximately 4% of oral contraceptive users.[15] The risk is increased by age, parity and obesity and is reversible after stopping the pill in the absence of other underlying causes. Considering the probable synergistic effect of hypertension and the development of vascular complications, blood pressure should be monitored closely in pill users with discontinuance if hypertension manifests. There are no conclusive data regarding the worsening of mild hypertension or the recurrence of hypertension following a pregnancy complicated by preeclampsia.

Endometrial carcinoma • There are numerous studies in the literature regarding the incidence of endometrial cancer and use of oral contraceptives. There is uniform agreement that the modern pill, with its daily progestin component, has a protective effect against endometrial cancer.[16] This is not surprising when considering the therapeutic value of progestins in the treatment of endometrial hyperplasia and cancer. The protective effect is greatest for nulliparous women, increases with use and is reported to last at least five years after discontinuance.[17]

Ovarian cancer • If the risk of ovarian cancer is related to the incessant stimulation of ovualtion, than the longer a woman remains anovulatory, as with oral contraceptive therapy, the lower the risk of neoplasia. The Centers for Disease Control reported a negative risk ratio for ovarian cancer in pill users of 0.6. The risk decreased with length of usage, and for those using the pill for greater than four years, the risk was 0.3. Protection was greatest for nulliparous women with the reduction of risk lasting ten years after cessation.[18]

Breast cancer • A very common concern among the general population of pill users is the concept of an increased risk of breast cancer. On the contrary, most all studies relating breast cancer and oral contraceptive usage either report no relationship or a possible protective effect.[19] At the same time, there is a reported significant decrease risk of benign breast disease, particularly fibrocystic disease.[20] In a very recent report of the large collaborative study from the Centers for Disease Control and the National Institute of Child Health and Human Development, there was found to be no increase risk for breast cancer in any category of oral contraceptive use.[21] There was no increase in risk related to dosage, formulation, duration of use and the time since last use. Also, there was no

significant differences in risk for users and never users when subgrouped according to menopausal status or family history of breast cancer. Furthermore, it is conceivable that breast cancer prognosis is improved in oral contraceptive users, possibly because increased surveillance improves early detection or that the steroids influence the virulence of the cancer.[22]

Cervical cancer • Attempting to correlate risk factors of cervical neoplasia is an epidemiologist's nightmare. It is widely accepted that sexual behavior influences these risks, making it near impossible to control for this confounding variable. It is very reasonable to assume that women on the pill are likely to be more sexually active, increasing exposure to the venereal transmission of agents thought responsible for cervical neoplasia. Family planning clincis in New York reported an increased incidence of carcinoma-in-situ of the cervix in women using the pill as compared to those using diaphragms.[23] Follow-up analysis using the same study group concluded that the differences were attributable to differences in populations choosing the pill versus thos choosing the diaphragm.[24] The Walnut Creek Study reported a 6.8 relative risk for carcinoma and carcinoma-in-situ for pill users ages 20-39 and a relative risk of 1.8 for ages 40-49.[12] Considering the common finding of cervical ectropian and a broadening of the transformation zone with oral contraceptive usage, it is very reasonable to believe that this would increase the incidence of abnormal pap smears and even cervical dysplasia, but an increase in invasive cancer has not been shown in any controlled study.

Hepatic tumors • Benign liver tumors have been shown to be increased with use of oral contraceptives.[25] These cases all involved women on the older, higher-dose pills. The increased rate was 1.2 per 100,000 users, still exceedingly rare. Also, no increase in the risk of hepatic malignancy in pill users has been found.

Summary • Oral contraceptives are one of the most thoroughly studied group of drugs in history. The general concern for adverse long-term consequences has not been substantiated in the medical literature as they relate to the currently used low-dose formulations. Also, the consideration of pill usage brings up the classic risk versus benefit issue. Too little press is given to the positive, noncontraceptive effects, such as the decrease in risk of endometrial and ovarian cancers. The early reports were concerned with the estrogen effects of the pill. These pills had from 50-150 mcg of estrogen. In an attempt to decrease the estrogen effect, the progestin was increased. What occurred was a trading of one set of adverse effects for another. The modern formulation of low-estrogen, low-progestin (usually given in a biphasic or triphasic regimen) should prove to lower long-term risks without decreasing benefits.

References

1. Spellacy, W.N.: Review of Carbohydrate Metabolism and Oral Contraceptives, Am. J. Obstet. Gynecol. 104:448, 1969.
2. Szabo, A.J.; Cole, H.S., and Grimaldi, R.D.: Glucose Tolerance in Gestational Diabetic Women During and After Treatment With a Combination-Type Oral Contraceptive, N. Engl. J. Med. 282:646, 1970.
3. Skouby, S.O.; Kuhl, C.; Molsted-Pedersen, L., et al: Triphasic Oral Contraception: Metabolic Effects in Normal Women and Those With Previous Gestational Diabetes, Am. J. Obstet. Gynecol. 153:495, 1985.
4. Spellacy, W.N.: Carbohydrate Metabolism During Treatment With Estrogen, Progestogen and Low Dose Oral Contraceptives, Am. J. Obstet. Gynecol. 142:732, 1982.
5. Krauss, R.M.: Effects of Oral Contraceptives on Lipid Metabolism, J. Reprod. Med. 31:549, 1986.
6. Bradley, D.D.; Winger, J.; Pettit, D.B., et al: Serum High-Density-Lipoprotein Cholesterol in Women Using Oral Contraceptives, Estrogens and Progestins, N. Engl. J. Med. 292:17, 1978.
7. Inman, W.H.W.: Thromboembolic Disease and Steroidal Content of Oral Contraceptives. Report to Committee on Safety of Drugs, Br. Med. J. 2:203, 1970.
8. Mann, J.I; Inman, W.H.W., and Thorogood, M: Oral Contraceptive Use in Older Women and Fatal Myocardial Infarction, Br. Med. J. 2:245, 1976.
9. Mann, J.I.: Myocardial Infarction in Young Women with Special Reference to Oral Contraceptive Practice, Br. Med. J. 2:241, 1975.
10. Mann, J.I.: Oral Contraception and Myocardial Infarction in Young Women, Data from Countries Other than the United States. In J.J. Sciarra, G.I. Zatuchni, and J.J. Speidel (eds.), Risk, Benefits and Controversies in Fertility Control. Hagerston, Md., Harper & Row, 1977.
11. Jick, H.; Dinan, B., and Rothman, K.J.: Oral Contraceptives and Non-Fatal Myocardial Infarction, JAMA 239:1403, 1978.
12. Ramcharan, S.: Walnut Creek Contraceptive Drug Study: Comprehensive Study of Side Effects of Oral Contraceptives: Vol. III. An Interim Report: Comparison of Disease Occurrence Leading to Hospitalization or Death in Users and Non-Users of Oral Contraceptives, National Institutes of Health Publication No. 81-564, January, 1981.
13. Porter, J.B.; Hunter, J.R.; Jick, H., and Stergachis, A.: Oral Contraceptives and Non-fatal Vascular Disease, Obstet. Gynecol. 66:1, 1985.
14. Royal College of General Practitioners: Oral Contraceptives and Thromboembolic Disease, J. R. Coll. Gen. Pract. 13:267, 1967.
15. Fisch, I.R.; Freedman, S.H., and Mayatt, A.V.: Oral Contraceptives, Pregnancy and Blood Pressure, JAMA 222:1507, 1972.
16. Weiss, N.S. and Saywetz, T.A.: Incidence of Endometrial Cancer in Relation to Use of Oral Contraceptives, N. Engl. J. Med. 302:551, 1980.
17. Herzberg, B.S.. Protection Against Endometrial Carcinoma by Combination Product Oral Contraceptives, JAMA 247:475, 1982.
18. Rosenberg, L.: Epithelial Ovarian Cancer and Combination Oral Contraceptives, JAMA 247:3210, 1982.
19. Vessey, M.P.; McPherson, K., and Doll, R.: Breast Cancer and Oral Contraceptives: Findings in Oxford Family Planning Association Contraceptive Study, Br. Med. J. 282:2093, 1981.
20. Ory, H.; Cole, P.; MacMahon, B., et al: Oral Contraceptives and Reduced Risks of Benign Breast Disease, N. Engl. J. Med. 294:419, 1976.
21. Cancer and Steroid Hormone Study of Centers for Disease Control and National Institute of CHild Health and Human Development: Oral-Contraceptive Use and the Risk of Breast Cancer, N. Engl. J. Med. 315:405, 1986.
22. Webster, L.: Epidemiology of Oral Contraceptives and Risk of Breast Cancer, J. Reprod. Med. 31:540, 1986.
23. Melamed, M.R.: Prevalence Rates of Uterine Cervical Carcinoma In-Situ for Women Using the Diaphragm or Contraceptive Oral Steroids, Br. Med. J. 3:195, 1969.
24. Dubrow. H.: Study of Factors Affecting Choice of Contraceptive, Obstet. Gynecol. Surv. 24:1012, 1969.
25. Vessey, M.P.: Oral Contraceptives and Benign Liver Tumors, Br. Med. J. 2:1064, 1977.

• Dr. Williams, University of South Florida College of Medicine, Department of OB/GYN, 12901 North 30th Street, Tampa 33612.

Nonsteroidal contraception — alternatives to the Pill

Michael S. Fernandez, M.D., F.A.C.O.G

ABSTRACT: This paper reviews the various forms of nonsteroidal contraception available. The history efficiency and safety of these methods are discussed.

Vaginal contraceptives are to family planning what a buffalo cart is to a modern transport system; more certain ways of solving the problem may exist, but to overlook the usefulness and potential acceptability of a simple solution to a common problem, especially a method that is of proven usefulness and perhaps also open to improvement, is shortsightedness.

— Malcolm Potts

The desire to control conception is a universal human phenomenon. Fragmentary knowledge of contraceptive means has existed in all major cultures throughout the history of social development. Each day in this country, millions of women attempt to control their reproductive destiny by using some form of contraception. Twenty-three percent of these women will use a nonsteroidal form of contraception.

In this article, an overview and update of various forms of nonsteroidal contraception including the barrier and fertility awareness methods will be presented. The history, efficacy and safety of these methods will be discussed and compared.

The diaphragm • There are many indications that from antiquity, women used various vaginal pessaries to prevent pregnancy. These included every imaginable herb and household item. One folk remedy called for a pessary made of crocodile and elephant dung bound together with earwax from animals.[1] The modern diaphragm was invented in 1838 by the German physician Dr. Frederick Wilde. It was popularized in the 1880s especially in Holland where it was known as the "Dutch cap" or "Dutch pessary."[2] An important development in the technology of the diaphragm was the introduction in the 1950s of agents that are today the active ingredients in most spermicides used in conjunction with

The Author
MICHAEL S. FERNANDEZ, M.D., F.A.C.O.G.
Dr. Fernandez is in private practice with Carrollwood Obstetrics and Gynecology, Tampa.

the diaphragm. Over the years several types of diaphragms have been marketed including the coil spring, flat spring, arcing spring, and the wide seal rim.

The diaphragm is inserted into the vagina up to two hours prior to coitus. It should be placed so that the posterior rim rests in the posterior fornix with the anterior rim fitting snugly behind the pubic bone. The dome of the diaphragm containing spermicidal cream or gel is in contact with the surface of the cervix. It should be left in place for at least six hours following sexual intercourse. The contraceptive effect depends partly on its function as a barrier, decreasing the degree of contact between semen and the cervix, and partly on its function as a spermicidal holder.

The goal in fitting the diaphragm is to select the largest rim size that is comfortable for the patient. The choice of size and rim type depends on the depth of the vagina and on perineal muscle tone.

Studies of diaphragm effectiveness have documented widely disparate rates. The difficulty in evaluating effectiveness appears to be related to the frequency of intercourse, user ability to master the proper technique, and user motivation regarding pregnancy prevention.

One of the lowest observed failure rates for diaphragm users was documented in 1976 by Mary Lane at the Sanger Bureau in New York. This two year study involving 2,175 women revealed an overall effectiveness rate of 98%.[3] This impressive success may reflect the thorough education program and careful fitting and prescribing procedures utilized in the study. However, other researchers have reported a wide range of accidental pregnancy rates from 7.7 pregnancies per 100 women per year (from the Hall study)[4] to 17 pregnancies (from the Ryder study).[5] A multicenter study involving 1,430 women by Edelman appears to be the most realistic with a pregnancy rate of 12.5.[6]

A common error in fitting the diaphragm is choosing a size that is too small. Vaginal depth increases during sexual arousal and a too-small diaphragm may fail to maintain its position covering the cervix. A diaphragm that is too large can cause vaginal pressure, abdominal pain or cramping, and vaginal ulceration. Recurrent cystitis is a complication frequently seen in women with a poorly fitted diaphragm.

Toxic shock syndrome has been reported in nine cases of diaphragm users.[7]

Contraindications to the use of the diaphragm are:[2] 1) History of toxic shock syndrome or vaginal colonization with S. aureus; 2) Allergy to latex rubber or spermicide; 3) Repeated urinary tract infections; 4) Abnormalities in vaginal anatomy such as uterine prolapse, extreme uterine retroversion or vaginal septae; 5) Inability of patient to learn proper insertion technique; 6) Temporary severe pelvic or introital pain due to any cause; 7) Full-term delivery within the past 6-12 weeks.

Protection against sexually transmissible disease appears to be an important noncontraceptive benefit of the diaphragm. One study of spermicide users, 50% of whom were diaphragm users, found that the relative risk of gonorrhea was less than one fourth that of oral contraceptive or surgical sterilization patients.[8] The risk for pelvic inflammatory disease among diaphragm users is about half that faced by noncontraceptive users. Whether or not diaphragm use offers protection against transmission of chlamydia, hepatitis, or AIDS virus is not known.

The vaginal sponge ● Probably the oldest mechanical intravaginal device used for contraceptive purposes is the vaginal sponge. Since antiquity, natural sea sponges, wads of cloth, cotton tufts, and the like have been used, alone or in combination with different spermicidal solutions. Dr. Clarence Gamble, a pioneer in international family planning, favored natural and synthetic sponges as well as pieces of cloth soaked with a saturated solution of sodium chloride before insertion. Because of local irritation and the general lack of water and privacy among the poor in the underdeveloped world, Gamble's effort met with poor response.[9] However, recently, there has been renewed interest in the possibility of this contraceptive modality.

In 1983 the FDA approved the first vaginal contraceptive sponge for marketing in the United States. This product, the Today Vaginal Contraceptive Sponge, is a small, pillow-shaped polyurethane device that contains one gram of nonoxynol-9 spermicide. This sponge has a depression on the side that fits over the cervix. The opposite side incorporates a woven polyester loop used to facilitate removal.

The sponge is available in one size without a prescription. It is moistened with tap water and then inserted deep in the vagina adjacent to the cervix. Once in place, it provides continuous protection for up to 24 hours. After use, the sponge is discarded. Its contraceptive action is two-fold by releasing spermicide contained within the sponge and by providing a barrier between sperm and the cervix, entrapping the sperm within the matrix of the sponge.

Many studies, both in the United States as well as in the international community, have been done to determine the effectiveness of the Today sponge and similar devices. Overall it appears that parous sponge users are twice as likely to become pregnant as are nulliparous users (28% versus 13%, respectively).[6] In contrast, both parous and nulliparous diaphragm users appear to experience the same failure rate of 13%.[10] It is possible that the size of the sponge is too small for maximum effectiveness in the parous woman. Other differences between nulliparous and parous women, such as inherent fertility or intercourse

frequency, may be responsible for the observed difference.

Contraindications in using the vaginal sponge are the same as with the diaphragm. Irritation or allergic reactions such as vulvar erythema are not unusual. Difficulty in inserting and removing the sponge can cause tearing of the device or require medical personnel to remove the sponge and its fragments from within the vagina. Other complaints include interference with intercourse, malodor, and vaginal dryness from excessive absorption by the sponge.

The estimated risk of toxic shock syndrome for sponge users (10 per 100,000) is similar to that for tampon users.[7]

For well motivated couples the method offers adequate contraception as well as convenience.

The cervical cap • The cervical cap is a thimble-shaped cup which fits over the cervix. It is held in place partly by suction and by intraabdominal pressure. In 1838 Friedrich Adoph Wilde, a German gynecologist, published a treatise discussing the development of a rubber cervical cap individually molded from a wax impression of the cervix and upper vagina. Caps popular in the United States 20 to 40 years ago were constructed of silver or copper and were left in place for as long as three to four months.[9]

In 1976 a thin cap molded of flexible plastic called the ContraCap was developed. Initial studies showed promise. The multicenter research program, however, was halted in early 1985 because of unacceptably high pregnant rates.[2]

Cervical caps may be purchased throughout the country although they are not currently approved for marketing as contraceptives in the United States. In England they are manufactured of soft rubber and are available in three styles.

Cervical caps are not suitable for prolonged vaginal retention in most women because of problems with a strong odor after 36-48 hours in the vagina and because of the theoretical risk of toxic shock syndrome. Spermicide inside the cap is recommended by the manufacturers.

Current research data on cervical cap effectiveness are limited. Failure rates of 8-16 per 100 women have been reported. A large prospective study is now underway in Los Angeles.[8] Preliminary data from this study for 313 cap users showed 5.7 pregnancies in the first six months.

Vaginal lacerations, abrasions, abnormal thickening of the vaginal wall, acute pelvic inflammatory disease, acute cervicitis, and development of abnormal pap smears have been observed in association with cap use. There are concerns regarding the effect of prolonged cervical exposure to secretions, spermicide, and bacteria trapped within the cap, and interference with the normal flow of cervical mucus or menstrual blood.

The condom • Mechanical barriers covering the penis have been used for centuries for protection against pregnancy and infection, for decoration, and occasionally to produce penile or vaginal stimulation. A sheath worn over the penis can be found in history as far back as 1350 B.C. The great Italian anatomist, Fallopius, described the use of linen sheaths in 1564. Protective devices from animal intestines soon followed. It was not until the 18th century that penile sheaths were given the name "condoms" and popularized by such libertines of the day as Casanova (1725-1798) as a means of "protection from venereal disease and numerous bastard offspring." With the advent of vulcanized rubber in the 1840s came mass production of condoms from synthetic materials. Today condoms are the second most popular contraceptive in the United States after the birth control pill.

Condoms are rubber or processed collagenous tissue sheaths which act as a barrier to the transmission of semen to the vagina. About 1% of condoms are animal skin condoms made from the cecum of young lamb intestines.

The failure rate of the condom is ten pregnancies per 100 women in a year. The use effectiveness rate approaches that of the pill when a spermicide is used in conjunction with the condom.

The major complaint of condom users is that it reduces penile sensitivity. Some men cannot retain an erection if a condom is used. Very rarely men and women have been allergic to the materials in the condom. Others object to the interruption of foreplay by the placement of the condom.

Condoms are a relatively inexpensive birth control method and are available without a prescription. They appear to play a major role in the prevention of sexually transmitted diseases, thus diminishing the likelihood of infertility or cervical neoplastic disease in some women.

The spermicides • Spermicidal substances have been in use for over 5,000 years. From the time of their discovery spermatozoa were known to be killed by many substances. Leeuwenhoek observed that dilution with rainwater rendered dog spermatozoa motionless. In 1855 Kolliker noted, in the first scientific study on the subject, that organic and inorganic salts were toxic to spermatozoa.

Presently available spermicidal preparations consist of two components. An inert base (usually cream, gel, or foam) serves to hold the spermicidal agent within the vagina against the cervix and interferes with the direct contact of the semen with the cervical mucus. The spermicidal chemical (usually nonoxynol-9 or octoxinol-9) kills the sperm.

There are several pharmaceutical modalities available for delivering spermicidal agents into the vagina: gel, cream, paste, foam, suppository, and

effervescent tablet. Gels offer greater lubrication but are messier than the creams which adhere better to the mucosa of the vagina and cervix. Foams are least messy since the greatest proportion of the vehicle is gas. Consequently they. appear to be aesthetically more acceptable to the patient.

Vaginal spermicides are readily available without prescription and are simple to use. They are a valuable adjunct for the barrier methods of contraception. Spermicides are detergents that will kill a number of the organisms responsible for sexually transmissible infections in vitro including gonorrhea, trichmonas, herpes, and chlamydia.[11] Women who use spermicides are less likely to develop pelvic inflammatory disease.[12] It has been suggested that spermicides might offer some protection against cervical neoplasia.[13]

There are several disadvantages and contraindications to using spermicides. Their use tends to interfere with sexual foreplay. The ingredients in the spermicide can cause chronic local allergy, genital contact dermatitis, eczema genitalis, genital psoriasis, and other genital dermatoses. So far, human studies have not documented adverse systemic effects.

Recent studies reported a postive association (relative risk of 2.8) between the occurrence of children with limb reduction and the use of spermicide. In view of a national rate of congenital defects of 2.1% and the lack of a single, well-defined syndrome, the clinical significance of these studies is doubtful.

Failure rates for spermicides are 22-29 pregnancies per 100 women per year. To minimize failures the spermicide must be placed deep in the vagina in the vicinity of the cervix and must be used consistently. Spermicidal creams and gels which appear to be slightly less effective than foam or suppositories are best used in conjunction with a diaphragm or cervical cap. Douching, even with a spermicidal solution, is not a reliable contraceptive technique.

Fetility awareness methods • Fertility awareness methods (natural family planning) have attracted much attention recently. They offer the advantage of being safe, inexpensive, and acceptable to most cultural and religious groups. Fertility awareness methods include the calendar method (rhythm method), the mucus method (ovulation or Billings method), and the symptothermal method.

Calendar method • Using a menstrual calendar the patient calculates her fertile period by assuming that ovulation occurs on the 14th day (plus or minus two days) before the onset of the next menses. To use this method the patient must record the length of each cycle and then subtract 18 days from the length of her shortest cycle and 11 days from the longest cycle. The two numbers calculated represent the beginning and end of her fertile period. During her fertile days, the patient must either abstain from intercourse or use another method of contraception.

Basal body temperature • By noting the daily basal body temperature or BBT (lowest body temperature of a healthy person during waking hours) a woman may determine her time of ovulation after several successive months. This is possible because the BBT of some women drops slightly immediately preceding ovulation. From 24-27 hours after ovulation, a noticeable rise in temperature occurs and persists until the onset of the next menses. A woman using the BBT method should avoid unprotected coitus starting no later than day four until the temperature has remained elevated for three consecutive days. To obtain an accurate BBT, it is best to take and record the BBT in the morning just after waking and before activity. A special BBT thermometer should be used and the temperatures can be taken either orally or rectally.

Mucus method • Changes in the character and appearance of cervical secretions occur just before ovulation in a predictable pattern in some women. In addition ovulatory pain may be experienced and can involve a feeling of heaviness, abdominal swelling, rectal pain, and lower abdominal pain on one or both sides. Observation of these physiological changes can help a woman determine her fertile period.

To use the mucus method, a woman must be taught the changes in the cervical secretions. The yellow viscous mucus normally present during the preovulatory and postovulatory phases of the menstrual cycle becomes clear and slippery during ovulation. A drop of this clear mucus can be stretched into a thin strand that measures six centimeters or greater. These changes persist for approximately 24 hours. A woman should keep a menstrual calendar for several months, recording the changes she observes. Intercourse should be restricted to the postovulatory phase of the cycle.

Symptothermal method • Combining elements of the mucus method and the BBT method improve the effectiveness of this approach to birth control. However, it does decrease the number of days on which the couple is permitted to have sexual intercourse.

The effectiveness of fertility awareness methods was best summarized in 1982 by the International Fertility Research Program: "Overall results have neither been good enough to convince those who doubt the usefulness of the method, nor poor enough to dim the enthusiasm of those who promote it."[14] Theoretical effectiveness rates of fertility awareness techniques are high but in actual use failure to implement the abstinence required decreases the actual effectiveness considerably. In the United States,

according to the World Health Organization survey of 1978, the effectiveness ranged from 70% with the calendar method to 80% with the mucus or Billing method. As expected, the symptothermal method achieved the highest effectiveness rate of approximately 90%.[15]

There is a body of data that suggests that the fertilization of an overripe ovum is associated with an increased incidence of pregnancy loss and congenital anomalies. However, the majority of the evidence is from studies done on nonhuman species or retrospective studies on women using various fertility awareness methods. There have been no prospective studies documenting an increased incidence of abnormal pregnancies. If there is an increased risk of abnormal offspring as a result of a contraceptive failure using one of the fertility awareness methods, it appears to be of low magnitude.

Coitus interruptus • Coitus interruptus or the withdrawal method is used by about 2% of American couples. As a method of birth control, withdrawal has the advantages of requiring no devices or chemicals and is available in any situation at no cost. It has, however, a failure rate of at least 16-23 pregnancies per 100 women per year and cannot be recommended as reliable. One reason for the high failure rate is because some preejaculatory fluid containing sperm can escape at any time prior to ejaculation. The likelihood of failure due to the release of this fluid increases with the occurence of multiple orgasms within a short time span. Another reason for contraceptive failure is a lack of the self-control demanded by this method. Interruption of the excitement phase of the sexual response cycle can markedly diminish the pleasure for a couple.

Conclusion • No contraceptive method is fully effective for preventing pregnancy, nor fully safe from both minor and major side effects, nor fully acceptable to all patients. Since each method has its advantages and disadvantages, the method that the couple will use in a consistent manner is most often the "best" contraceptive method for them.

References

1. Robertson, H.R.: Contraception: Past, Present and Future, Ala. J. Med. Sci. 12(4):316-321, 1975.
2. Hatcher, R.A., et al: Contraceptive Technology 1986-87, New York, Irvington Publishers, pp. 214-248.
3. Lane, M.; Arleo, R., and Sobrero, A.J.: Successful Use of Diaphragm and Jelly in a Young Population: Report of Clinical Study, Fam. Plann. Perspec. 2:81-86, 1976.
4. Hall, R.E.: Continuation and Pregnancy Rates with Four Contraceptive Methods, Am. J. Obstet. Gynecol. 116:571-581, 1973.
5. Ryder, N.B.: Contraceptive Failure in United States: Impact of Social, Economic and Demographic Factors, Fam. Plann. Perspec. 14:68-75, 1982.
6. Edelman, D.A.; McIntrye, S.L., and Harper, J.: Comparative Trial of the Today Contraceptive Sponge and Diaphragm, Am. J. Obstet. Gynecol. 150:869-876, 1984.
7. Centers for Disease Control: Toxic Shock Syndrome and the Vaginal Contraceptive Sponge, M.M.W.R. 33:43-48, 1984.
8. Sherris, J.D.: New Developments in Vaginal Contraception, Pop. Reports Series H Number 7, 1984.
9. Sobrero, A.J.: Use and Effectiveness of Condom, Diaphragm, Cervical Cap, Vaginal Sponge, and Spermicides, Chapter 17: Sciarra J. W., (ed.) Gynecology and Obstetrics, Philadelphia, Harper & Row, pp 1-32.
10. McIntyre, S.L. and Higgins, J.E.: Factors Related to Pregnancy Rates Obtained by Contraceptive Sponge Users, presented at 22nd Annual Meeting of Association of Planned Parenthood Professionals, November 2-3, 1984, San Antonio, Texas.
11. Cutler, J.C.; Singh, B.; Carpenter, U., et al: Vaginal Contraceptives as Prophylaxis Against Gonorrhea and Other Sexually Transmissible Disease, Advances Planned Parenthood 12(1):45-56, 1977.
12. Kelaghan, J.; Rubin, G.L.; Ory, H.W.S., and Layde, P.M.: Barrier-Method Contraceptives and Pelvic Inflammatory Disease, JAMA 248(2):184-187, 1982.
13. Jackson, M.; Berger, G.S., and Keith, L.G.: Vaginal Contraception, Boston, G.K. Hall Medical, 1981.
14. Anonymous: Natural Family Planning Under Study at IFRP, Network, Quarterly Publication of International Fertility Research Program, 3:1-23, 1982.
15. World Health Organization: Special Programme of Research, Development and Research Training in Human Reproduction: Seventh Annual Report, Geneva, World Health Organization, November 1978.

• Dr. Fernandez, 11212 N. Dale Mabry, Suite 901, Tampa 33618.

Contraception and the law: medical-legal trends affecting availability of contraception in the United States

Robert W. Yelverton, M.D., F.A.C.O.G.

Obstetrics and gynecology, perhaps greater than any other specialty, has been dramatically affected by the crisis of excessive liability litigation. Overshadowed by the more dramatic issue of liability involving the brain-damaged baby, less attention has been focused on the import of this crisis upon availability, cost, and research in methods of pregnancy prevention. This article presents a historical review of the legal events that have drastically altered, perhaps forever, the physicians' ability to prescribe a wide range of effective contraception, individualized to his patient's needs. This article also attempts to present guidelines for the prescribing of contraceptive methods in a fashion which will be both safe for the patient and minimize the liability risks of prescribing such methods.

Legal theory of products liability and its impact on availability of current and future contraceptive methods • Products liability law deals with the liability imposed on manufacturers and suppliers of products for harm caused by defects in their products.[1]

A person injured by a defective product who decides to sue the manufacturer or seller may do so under three products liability theories listed in their order of chronological development:

1. Negligence, in which an injured party must show that a specific manufacturer or seller failed to exercise proper care in manufacturing or marketing the allegedly defective product.

2. Warranty, in which an injured party need not prove negligence but instead must show that the manufacturer or seller breeched an expressed or implied promise that the product was free from defects and was fit for the ordinary purposes for which such products are used.

The Author
ROBERT W. YELVERTON, M.D., F.A.C.O.G.
Obstetrics and Gynecology at the University of South Florida College of Medicine, and in private practice in Tampa.

3. Strict liability in tort, in which an injured party need not prove negligencc or breech of warranty but must show only that the product causing the injury was defective when it left the hands of the manufacturer or seller.

In many ways each developing theory of products liability made it easier for a plaintiff to recover against the defendant. Moreover, each successive theory merely supplemented rather than replaced its precursors. Any single theory or all three theories may be applied for a specific case in jurisdictions where all these theories are allowed. As a result of these increasingly plaintiff oriented theories, products liability cases against manufacturers of medical products have been more successful than in the past, leading to a huge increase in the number of suits filed.[2]

The skyrocketing increase in products liability suits nationwide has had a dramatic impact on the availability of many medical products but the most significant event has been the near total demise of the intrauterine device (IUD) as a choice for American women when choosing a contraceptive method. In January 1986 the IUD was nearly eliminated from the American market when the G.D. Searle Corporation discontinued the sale of the Copper-7 and the Tatum-T IUDs in the United States.[3] Searle, whose IUDs were used by more than a million American women, stated that the high cost of defending unwarranted lawsuits forced its action.

United States sale of the Searle IUD reached $11 million in 1985, but Searle spent more than $1.5 million to fend off just four lawsuits in 1985. Eight hundred suits were filed against Searle in conjunction with the manufacturing and sale of IUDs and 305 cases are still pending. Many cases were settled before trial, usually for less than $10 thousand. Out of 11 trials, Searle won nine and lost two. Searle sensibly decided that it was no longer economically feasible to continue the United States sale of its very successful IUDs. These IUDs continue to enjoy a highly profitable foreign market.[4]

The safety of IUDs has been a matter of controversy since they were initially introduced in Germany more than 50 years ago. The most serious complication associated with the product was the acknowledged increased risk of pelvic inflammatory disease which in turn may be associated with sterility, ectopic pregnancy and, if tuboovarian abscess develops, hysterectomy and oophorectomy.[5] With the development of plastic and mental IUDs these complications were believed to be minimal with an acceptable risk-benefit ratio.

Then came the now notorious Dalkon Shield disaster. Reports from the mid- and late 1970s began to demonstrate a comparatively high rate of infectious complications with the Dalkon Shield. In contrast to the loop and copper IUDs which have a monofilament tail string, the shield has a multifilament tail string. Studies in both humans and animals demonstrated that this type of appendage provides a method for bacteria to ascend to the upper genital tract during the entire time that the IUD is in place and thus increases the risk of salpingitis.[6,7] These problems were compounded by the fact that plaintiff attorneys, investigating possible negligence by the Dalkon Shield manufacturer, A.H. Robins, uncovered evidence that suggested the company was aware that the Dalkon Shield multifilament tail string was defective prior to the shield's marketing from 1972-1974. The plaintiffs also successfully demonstrated that, despite numerous reports of pelvic inflammatory disease, septic abortions, and fatalities among Dalkon shield users, A.H. Robins continued to market the product without effective warnings. The plaintiffs also presented evidence suggesting that the company initiated a program to manipulate the scientific information about the Dalkon Shield so that only favorable reports might be published.[8] These allegations led, of course, to a flood of lawsuits. Overwhelmed by 9,450 lawsuits that cost $490 million plus 6,000 pending legal claims, A.H. Robins filed for bankruptcy August 21, 1985.[3]

In the aftermath of A.H. Robins failure, Johnson & Johnson's Ortho Pharmaceutical Corporation, citing decreased sales and liability problems (200+ lawsuits), stopped production of the Lippes loop in September 1985. The Safety-T-Coil made by Julius Schmid was also removed from the market.[9] This left Alza Corporation's Progestasert, an IUD similar to the Tatum-T in design but containing a small amount of progesterone instead of copper, as the only IUD on the U.S. market.[7]

Even when A.H. Robins was entangled in thousands of lawsuits against its apparently defective IUD, Searle was not overburdened with lawsuits against its CU7. Studies demonstrated that of all the IUDs, Searle's Copper IUDs were associated with the least amount of pelvic inflammatory disease. There was general agreement that the CU7 was much safer than the Dalkon Shield.[4] A relatively small group of plaintiff attorneys, specializing in IUD cases, was filing the majority of IUD lawsuits. These attorneys were so busy litigating successfully thousands of actions against the Dalkon Shield, they had little time or financial incentive to pursue the relatively few complaints against Searle's safer CU7. Robins' bankruptcy changed all that. For several years, attorneys working on Dalkon Shield litigation maintained acceptable cash flow on the settlements A.H. Robins grudgingly anted to reduce the number of cases pending against it. When Robins filed for bankruptcy, every pending case against the company was consolidated in the bankruptcy court. No plaintiff or his attorney will receive financial compensation from

A.H. Robins until the bankruptcy matter is settled. Thus, the Robins' bankruptcy created a serious cash flow problem for attorneys litigating Dalkon Shield cases.

In the course of collecting clients for the Dalkon Shield litigation, however, attorneys had occasionally discovered other women complaining of pelvic inflammatory disease (PID) and infertility. They had used the CU7. Now, hurting economically from Robins' bankruptcy, a small group of attorneys, led by Baltimore personal-injury lawyer, Mike Pretel, mounted an all-out legal attack against Searle's CU7.[4] The attack has not been easy or too successful to date. As mentioned, studies demonstrate that of all the IUDs, the Copper IUD was associated with the least amount of PID.[10,11]

Pretel, along with other attorneys, has organized an elaborate system of "networking" information against the CU7. These attorneys share information learned through "discovery" — the process prior to trial in which both sides hand over documents requested by a party and experts are deposed to learn what they will say at trial. These attorneys are also combing through some 600,000 documents Searle has given them regarding clinical studies and marketing strategies of its device. The documents will be scrutinized, computerized, and then shared by all these attorneys to assist in case preparation.

So far, the attorneys have not found the "smoking gun" that will place Searle in a vulnerable position, but the withdrawal of the Copper IUDs from the market is likely to be permanent.[4]

As previously mentioned, one IUD is still available in the United States. Alza Corporation's "Progestasert Intrauterine Contraceptive System" has been available since 1976. This IUD is a T-shaped plastic device that slowly dispenses the hormone progesterone directly into the uterus. More expensive and requiring annual replacement, the Progestasert IUD accounted for only 10% of the U.S. market (50,000 devices annually) in 1985.

By leaving the Progestasert IUD on the market, Alza is assuming a great risk in its attempt to capture a significant portion of the $100 million IUD business. The publicity surrounding Searle's withdrawal of the copper devices is likely to reduce consumer confidence in the IUD. Also Alza's new, long, detailed informed consent form accompanying the IUD is likely to discourage both consumer and physician alike.[12]

At least one market analyst, Richard R. Vietor, believes that Alza will not be able to afford liability coverage or to provide a desirable product. In the past ten years Alza has paid a total of $250,000 to settle all claims against all of its products, including the Progestasert. This is miniscule compared to the potential cost of lawsuits in the future.[12] Many analysts share the view of Dr. Bruce Stadel of the National Institutes of Health who states "a pharmaceutical company would have to be altruistic to the point of suicidal to market an IUD today."[13] A similar sentiment may soon apply to other methods of contraception as well. Long considered to be more safe than effective, barrier methods of contraception, condoms, foam, jellies, diaphragms, and sponges, have recently lost their relative immunity from serious legal attacks from plaintiffs claiming injury. In early 1986, despite overwhelming expert testimony citing its safety, a jury awarded $4.7 million in damages to a woman who claimed that her child's birth defects resulted from the use of Ortho-Gynol Jelly. The decision was upheld May 6, 1986, by a Federal Appeals Court. Although Ortho Pharmaceutical Corporation backs the safety of its product and has no immediate plans to discontinue its use, cost of future litigation could force Ortho to discontinue this product.[13] A scattering effect, similar to events leading to the demise of most IUDs, could threaten the entire product line of contraceptive foams and jellies and those barrier methods that are often used in conjunction with these products such as condoms, diaphragms and sponges.

Oral contraceptive pills have not been immune to products liability litigation but fortunately this method of contraception is not likely to be severely affected. Oral contaceptive pills are very profitable for the pharmaceutical houses that supply them ($600 million in 1985). This method of contraception has been extensively researched as to its safety and risks have been well described. Newer low-dose pills are considered much safer than the pills offered a decade ago. Oral contraceptives have approximately 40% of the contraceptive market.[12] Consumer confidence, following recent reports confirming the safety of birth control pills, is increasing.

Just as products liability legislation has had a devastating impact on the availability of current contraceptive methods, the over-utilization of its theories has equal impact on the potential for research, development, and marketing of newer, more advanced systems of contraception. Few if any pharmaceutical corporations are willing to stake their very existence on marketing a new product in such a litigious market as contraceptive devices or systems. New systems currently under investigation include Silastic and biodegradable subdermal implants containing progesterone, injectable systems, and vaginal, cervical and intrauterine systems that release steroid hormones.[14]

Norplant, a Silastic implant that releases progesterone for five years, is currently available in five countries and is considered the most promising new system. This implant was developed by scientists of the New York City-based Population Council and will be submitted to the FDA for approval in 1987. But even if Norplant gains acceptance, it is unlikely that any American corporation will market it domestically because of the potential for liability problems. If U.S.

consumers want newer, better contraceptives, they, along with their attorneys, will have to change their attitudes. There never has been and probably never will be a contraceptive device that is risk-free.[13]

No relief is in sight for the manufacturers of medical products beleaguered by excessive products liability lawsuits. During the last decade, Congress has struggled with products liability reform to eliminate inconsistent and contradictory state laws which make it difficult for manufacturers who sell products in more than one state. Several versions of products liability legislation have been considered by the U.S. Senate Commerce Committee. In 1984 legislation to set federal standards for lawsuits brought by victims charging that they were injured by unsafe products was reported favorably by the Commerce Committee but never reached the Senate floor because of disagreement between manufacturers, trial lawyers, unions, consumers, and state officials who opposed preemption of state laws. Although the Senate Commerce Committee reported out a much compromised products liability bill during this session of Congress, prospects for passage appeared dim. Some senators opposed to the cap on pain and suffering included in the products liability bill have already indicated that they will filibuster the bill when it reaches the Senate floor.

Although several products liability bills are also pending in the U.S. House of Representatives, as of July 1986 there has been no action on them.

Legal theory of malpractice and its impact on the physician's role in prescribing contraceptive methods — guidelines to minimize legal risk ● Patients have always been able to sue their physicians under the American legal system. Until the 1950s, however, malpractice lawsuits were relatively rare. Beginning in the 1960s the number of lawsuits has increased at an astounding rate.

The term "malpractice" refers to any professional misconduct that embodies an unreasonable lack of skill or fidelity in carrying out professional duties. The purpose of a malpractice lawsuit is to afford recovery for damages sustained as a result of a physician's failure to exercise ordinary and reasonable care in the treatment of a patient.[2]

Malpractice and oral contraceptives ● Liability may be imposed on a physician prescribing oral contraceptives for failure to take a complete patient history, failure to thoroughly examine the patient, failure to adequately warn the patient of the risks involved, failure to monitor the patient for the symptoms of adverse reactions, or failure to recommend a waiting period between the use of oral contraceptives and becoming pregnant.[2]

Oral contraceptives are indicated for (1) contraception, (2) menorrhagia, (3) dysmenorrhea, and (4) oral contraceptives are possibly indicated for benign functional cysts of the ovary and for the management of endometriosis. Oral contraceptives are contraindicated in (1) thrombophlebitis, thromboembolic disorders, (2) cerebral vascular or coronary artery disease, (3) markedly impaired liver functions, (4) known or suspected estrogen dependent neoplasms, (5) known or suspected carcinoma of the breast, (6) undiagnosed abnormal genital bleeding, (7) known or suspected pregnancy, and (8) benign or malignant liver tumors which develop during the use of oral contraceptions. To protect yourself legally when prescribing oral contraceptives, adhere strictly to indications and contraindications, be thoroughly familiar with the adverse effects of the pill, and instruct your patient to read carefully all product information and instructions provided with the pill brochure. Document carefully that this was done.

The following situations are among those that may place the physician in legal jeopardy when prescribing birth control pills.

1. Failure to warn the patient of increased risks associated with smoking, advanced age, or medical disorders such as cardiovascular disease, diabetes, renal or hepatic disease.
2. Failure to discontinue when signs of pregnancy exist, i.e., amenorrhea.
3. Failure to discontinue when hypertension develops.
4. Failure to discontinue with the onset of or exacerbation of migraine headaches, or development of headaches of a new pattern.
5. Failure to discontinue with the development of significant visual disturbances.
6. Failure to discontinue with the onset of jaundice or symptoms of gallbladder disease.
7. Failure to investigate persistent abnormal bleeding while on birth control pills.
8. Failure to inform patient of potential decreased efficacy of birth control pills when taking other medications (ampicillin, tetracycline, barbiturates, phenylbutazone, phenytoin sodium).
9. Failure to advise patient to delay pregnancy for an interval following cessation of birth control pills.
10. Failure to prescribe the lowest available dose that is tolerated by the patient.
11. Failure to educate office personnel advising patients as to the significant adverse reactions associated with the birth control pills (remember a physician is usually vicariously liable for actions of his office personnel).
12. Failure to adequately monitor a patient following prescribing of birth control pills.
13. Failure to document that appropriate warnings and/or patient information brochures were given prior to prescribing.

14. Failure to document that a complete history was obtained and physical examination performed prior to prescribing.

Malpractice and intrauterine devices • Liability may be imposed on a physician regarding the use of IUDs for failure to inform and continue to inform the patient of risks associated with use, failure to take a complete history and perform a thorough examination, negligent insertion or removal of the device, negligence in determining that the device is properly in place, failure to advise and warn a patient about risks associated with pregnancy occurring while the IUD is in place, or failure to adequately monitor the patient for adverse reactions associated with the device.[2]

With the current legal climate and adverse publicity surrounding IUDs, many physicians have discontinued prescribing IUDs completely. Others have continued to do so but only in former IUD wearers willing to assume the risks. Few physicians will prescribe the IUD as a new method of contraception except in very individualized situations. Although this practice may not be the best medically, it certainly makes sense from a medical-legal standpoint.

A physician's legal liability associated with prescribing the IUDs is obvious. He must be aware of the absolute and relative contraindications to inserting an IUD and must document that these were discussed fully with the patient.

The following less obvious situations have been among those that may place the physician in legal jeopardy when prescribing the IUD.[2]

1. Failure to document either the presence or absence of an IUD when the tail is not visible on pelvic examination by one of the following methods: a. palpation of the IUD by vaginal instrumentation; b. ultrasound; c. x-ray with the position of the uterine cavity indicated by the placement of a metal uterine sound, x-ray dye or insertion of a second IUD.
2. Failure to remove an IUD in early pregnancy when IUD tail is clearly visible.
3. Failure to inform patient of relative contraindications when these conditions did actually exist, i.e., patient on anticoagulants, patient with vulvular or congenital heart disease or valve prostheses who is prone to bacterial endocarditis.
4. Patients with menorrhagia who are prone to anemia.
5. Inserting an IUD in patients with absolute contraindications such as pregnancy or suspicious symptoms of pregnancy, abnormalities of the uterus resulting in distortion of the uterine cavity, acute salpingitis or history of repeated pelvic infections, postpartum endometritis or recent infected abortion, or insertion of Copper IUDs with a history of copper allergy or Wilson's disease.
6. Failure to examine a patient within three months of insertion.

Malpractice and sterilization • Liability may be imposed on a physician in connection with a tubal ligation when: (1) the informed consent of the patient is not obtained; (2) the operation is unnecessary (having been performed as a treatment for a mistakenly diagnosed illness); (3) the operation is negligently performed and the patient suffers additional injury, and (4) the patient is mentally incompetent and proper legal authority is not obtained.[2]

Women desiring elective surgical sterilization should be fully counseled as to the implications of this surgery. Informed consent requires that the patient understand: (1) that the procedure is intended to be permanent; (2) that there can be no guarantee of the effectiveness of the procedure, and (3) that the restoration of fertility by subsequent operation is uncertain.

Consultation is not necessary if sterilization is requested by the patient. If the decision for sterilization is complicated by medical or psychiatric problems, the opinion of a knowledgeable consultant is wise.[2]

Surgeons should familiarize themselves with failure rates associated with various methods of tubal sterilization and consider informing the patient in advance of the various technique options and their anticipated failure rates. For instance, when performed in conjuction with a cesarean section, the Madlener technique has a failure rate as high as 2%, whereas the Irving method has failure rate of less than 0.1%.

References

1. Prosser, W.: Handbook of the Law of Torts, 4th ed., 1971, p. 139.
2. Fineberg, K.S.; Obstetrics, Gynecology and the Law, Health Administration Press, 1984.
3. Birth control — vanishing options, Time, September 1, 1986.
4. Rust: Death of a Medical Device, American Medical News, August 22, 1986, p. 1.
5. Mishill, D.R.: Current Status of IUDs, N. Eng. J. M. 312:984, 1985.
6. Tatum, H.J.; Schmidt, F.H., and Phillips, D.M.: Morphological Studies of Dalkon Shield Tails Removed from Patients, Contraception 11:465, 1975.
7. Skangalis, M.; Mahoney, C.J., and O'Leary, W.: Microbial Presence in Uterine Cavity as Affected by Varieties of Intrauterine Contraceptive Devices, Fertil. Sterili. 37:263, 1982.
8. Husbands vs. A.H. Robins Co., U.S. District Court, S.D. Fla., No. 82-2763-J.K., September 6, 1984.
9. Goodbye IUDs, Contemporary OB-GYN 27:167, 1986.
10. Cramer, et al: Tubal Infertility and Intrauterine Device, N. Engl. J. M. 312:941, 1985.
11. Doling, J.R., et al: Primary Infertility in Relation to Use of Intrauterine Device, N. Engl. J. M. 312:937, 1985.
12. Hamilton, J.K.: Business Week, February 24, 1986, p. 123.
13. Toufexis, A.: Time, 1986, p. 78.
14. Downey, P.D.: Contraceptives: Are Implants the Answer? Contemporary OB/GYN 28:29, 1986.

• Dr. Yelverton, 2727 W. Buffalo, Suite 600, Tampa 33607.

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

- —drug and disease information
- —clinical abstracts
- —administrative and medical-practice information
- —Continuing Medical Education courses
- —Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC.
P.O. BOX 2411, JACKSONVILLE, FL 32203
TELEPHONE 904/356-1571

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

CONFIRMED

CONFIRMED BY CLINICAL EVIDENCE

ZANTAC® 150 h.s.

ranitidine HCl/Glaxo 150 mg tablets

EFFECTIVE MAINTENANCE THERAPY

for healed duodenal ulcer patients

CONFIRMED

In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

		0-4 months	0-8 months	0-12 months	No. patients
USA[1]	ranitidine 150 mg h.s.	9%	14%*	16%†	60
	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia[2]	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*p=0.02
†p=0.01
‡p≤0.004
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a

low incidence of side effects[3]

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the **ADVERSE REACTIONS** section in the Brief Summary.

No significant interference with the hepatic cytochrome

P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime
for maintenance

See next page for references and
Brief Summary of Product Information.

Glaxo / ROCHE®

CONFIRMED

Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients

References:

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

See complete product information before prescribing. The following is a brief summary

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy. 2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function. Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: *Teratogenic Effects: Pregnancy Category B:* Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

See full prescribing information for dosage adjustment for patients with impaired renal function.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

© Copyright 1983, Glaxo Inc. All rights reserved.

June 1986

Glaxo

Glaxo Inc.
Research Triangle Park, NC 27709

SPECIAL ARTICLE

A review of the new statutory changes in Florida governing the policy of obtaining a medical license by examination

Richard J. Feinstein, M.D.

The recently enacted Medical Practice Act, Florida Statutes, Chapter 458, has significantly changed the provisions for licensure by examination. I will review the statute, 458.311, and make comments after each section.

458.311

(1) Any person desiring to be licensed as a physician shall apply to the department to take the licensure examination. The department shall examine each applicant whom the board certifies:

(a) Has completed the application form and remitted a nonrefundable application fee not to exceed $100 and an examination fee not to exceed $500, which is refundable if the applicant is found to be ineligible to take the examination.

(b) Is at least 21 years of age.

(c) Is of good moral character.

(d) Has not committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331.

(e) For any applicant who has graduated from medical school after October 1, 1992, has completed the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which shall include at a minimum, courses in such fields as anatomy, biology, and chemistry prior to entering medical school.

Section (1)(a) through (e) deals with general qualifications of applicants who seek a medical license by examination. Subsection (e) represents a change in that it will require all candidates, graduates of both foreign and U.S. medical schools, to have at least two years of preprofessional academic education, in specified subject areas, often referred to as premedical curricula, in order to be eligible to take the Florida licensing examination. This will not become effective until applicants begin to apply who have graduated from medical school on or after October 1, 1992. Presently all U.S. medical graduates meet these requirements, and most have their baccalaureate degree from a preprofessional college program.

(f) Meets one of the following medical education and postgraduate training requirements:

1.a. Is a graduate of an allopathic medical school or allopathic college recognized and approved by an accrediting agency recognized by the United States Office of Education; and

b. If the language of instruction of the medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

Subsection (f) 1.a through 1.c deals with graduates of United States and Canadian medical schools who seek license through examination. They must attend schools accredited by an agency recognized by the U.S. Office of Education; i.e., the LCME (Liaison Committee on Medical Education). Although b. refers to education in another language, I do not believe that there are any LCME accredited medical schools, except those in Puerto Rico, that use any other language. The graduates of accredited schools require a medical degree; one year of residency (PGY I), and then they are eligible for the FLEX, and licensure.

2.a. Is a graduate of a foreign medical school registered with the World Health Organization and certified pursuant

The Author
RICHARD J. FEINSTEIN, M.D.
Dr. Feinstein is Clinical Associate Professor of the Department of Dermatology of the University of Miami School of Medicine, Miami.

to s. 458.314 as having met the standards required to accredit medical schools in the United States or reasonably comparable standards;

b. If the language of instruction of the foreign medical school is other than English, has demonstrated competency in English through presentation of the Educational Commission on Foreign Medical Graduates English proficiency certificate or by a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

Section 2.a. represents a departure from prior legislation regulating eligibility of foreign medical graduates for licensure by examination. The law now bifurcates foreign medical graduates into two categories: under 2.a. are those who graduate from a foreign school which will be inspected and certified by the Florida Department of Professional Regulation, as described in section 458.314. Please refer to that section to see what type of certification process DPR intends to institute.

Graduates of foreign schools certified by DPR must present a medical degree from that school; have the ability to speak and understand the English language; and complete a full year of approved residency, PGY I, before they are eligible to take the FLEX examination and receive a license.

3.a. Is a graduate of a foreign medical school which has not been certified pursuant to s. 158.314; and

b. Has had his medical credentials evaluated by the Education Commission on Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the Foreign Medical Graduate Examination in the Medical Sciences or the Educational Commission for Foreign Medical Graduates Examination; and

c. Has completed an approved residency of at least 1 year; however, after October 1, 1992, the applicant shall have completed an approved residency of at least 3 years in one specialty area.

Section 3.a. pertains to foreign medical graduates from schools that have not been certified by the Florida DPR. These applicants will be expected to fulfill more stringent requirements because they have graduated from schools unknown to the medical board, which have not been subjected to the inspection process.

These graduates must be certified by the Educational Commission on Foreign Medical Graduates, ECFMG, which includes the passage of the FMGEMS examination: Foreign Medical Graduate Examination in the Medical Sciences which has replaced the VQE and the ECFMG tests. They must then complete one full year of approved residency, PGY I, before being eligible to take the FLEX test and obtain a Florida medical license.

Applicants from non-DPR credentialled foreign medical schools who apply after October 1, 1992 will have to complete a three year residency, PGYI-III, in one specialty area, before they can take the FLEX and obtain a license.

(2) Every applicant who is otherwise qualified may take the licensing examination five times after October 1, 1986, notwithstanding the number of times the examination has been previously failed. If an applicant fails the examination taken after October 1, 1986 five times, he shall no longer be eligible for licensure.

After trying for five years to place a limitation on the number of attempts a candidate could have at passing the state licensing examination, FLEX, the Board of Medical Examiners by rule, limited the number of attempts to five. The Board set the limit to five, regardless of the number already taken when the applicant applied to the Florida Board to take the examination again. The Legislature was unhappy by what it perceived was retroactive application of the rule.

By this section, the Legislature is now giving every applicant an additional five attempts to pass the examination, no mater how many prior attempts were made.

(3) Notwithstanding the provisions of paragraph (1)(f)3., a graduate of a foreign medical school need not present the certificate issued by the Educational Commission for Foreign Medical Graduates or pass the Foreign Medical Graduate Examination in the Medical Sciences or the Educational Commission for Foreign Medical Graduates examination if he:

(a) Has completed undergraduate work in an accredited United States college or university.

(b) Has studied at a medical school which is recognized by the World Health Organization.

(c) Has completed all of the formal requirements of the foreign medical school, except the internship or social service requirements, and has passed part I of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent.

(d) Has completed an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion has passed part II of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent.

Section (3) applies to the so-called Fifth Pathway to medical licensure and applies to graduates of foreign medical schools which require a fifth year of medical education, which is served as a social year, taking care of poor patients in remote areas of the country, outside the direct supervision of medical school educators. All medical schools in Mexico require the fifth social year before granting the titulo, or medical degree to graduates.

Without the presence of an actual medical degree, students from these medical schools found it difficult to obtain a medical license in most states, despite having completed the major aspects of the medical school curriculum. In order to facilitate their needs, the Fifth Pathway process was developed, as outlined in this section. Having completed undergraduate courses at a U.S. college or university (the only

section relating to foreign medical graduates which now requires undergraduate premedical education); studied at a WHO medical school (which applies to all medical schools in the world); completed all the medical education except the fifth or social year and internship; completed a fifth year at a special academic institution for Fifth Pathway students (there are none in Florida, and most students attend the one at Mt. Sinai Hospital in New York City); and passed part I and later part II of the National Board of Medical Examiners test.

This subsection is repealed effective October 1, 1991.

(4) The department shall issue a license to any applicant who has met the requirements of this section and has obtained a passing score, as established by rule of the board, on the licensure examination of the Federation of State Medical Boards of the United States, Inc. (FLEX) or on Part III of the examination of the National Board of Medical Examiners; however, the FLEX or Part III of the National Board examination shall have been passed within 10 years immediately preceding the filing of his application for licensure under this section.

(5) Each applicant who passes the examination and meets the requirements of this chapter shall be licensed as a physician, with rights as defined by law. The department may not issue a license to any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter until such investigation is completed. Upon completion of the investigation, the provisions of s. 458.331 shall apply.

Section (4) continues the policy of granting a license to anyone who passed FLEX or the National Board examination within the prior ten years. Section (5) is self explanatory, allowing the board to deny licensure to anyone who is being investigated in another state.

(6) Notwithstanding any of the provisions of this section, the department shall issue a restricted license to any applicant who successfully completes the Florida Board Examination and who the board certifies has met the criteria of paragraph (a) or paragraph (b) as follows:

(a)1. Is a graduate of a foreign medical institution located in a country in the Western Hemisphere with which the United States does not maintain diplomatic relations;

2. Received a medical education which was substantially similar at the time of the applicant's graduation to approved United States Medical programs;

3. Has resided in Florida for at least three years immediately preceding his application;

4. Practiced medicine in a foreign country from which he immigrated to the United States of America and has lawful immigration status, including employment authority; and

5. Successfully completed the Educational Commission for Foreign Medical Graduates Examination or Foreign Medical Graduate Examination in the Medical Sciences or successfully completed a course developed by the University of Miami for physician training equivalent to the course developed for such purposes pursuant to chapter 74-105, Laws of Florida; or

(b) Obtained a certificate of completion from the program established at the first accredited medical school pursuant to chapter 74-105, Laws of Florida, prior to January 1, 1982.

(c) The holder of a restricted license issued pursuant to this subsection may only practice medicine under the direct supervision of a physician with an active, valid license issued pursuant to s. 458.311 or s. 458.313.

(d) Upon demonstration to the board that the holder of a restricted license issued pursuant to this subsection has practiced for 1 year under direct supervision, has had no malpractice suits filed against him, and has not committed any act or is not under investigation for any act which would constitute a violation of this chapter, the department shall issue an unrestricted license to the restricted license holder.

(e) The Florida Board Examination may be translated into a foreign language at the request of no fewer than five applicants who are otherwise qualified pursuant to this subsection, however, the cost of such translation shall be paid by such applicants.

(f) The first sitting for the Florida Board Examination shall be held by no later than February 2, 1987, and shall be offered in 6-month intervals thereafter.

Subsection (6) deals with an entirely new issue; a special new category of medical licensure in Florida; the Restricted medical license. This section also discusses the legislative demand that the Board of Medical Examiners prepare and administer a new examination, the Florida Board Examination.

Many states gave their own licensure examination over the past 100 years, but slowly states began utilizing a single professionally prepared and psychometrically correct examination, which has been created by the National Board of Medical Examiners and offered under the auspices of the Federation of State Medical Boards. Florida began utilizing the FLEX in 1979, and all fifty states now do so.

The Restricted medical license, as described in this subsection, will be granted to someone who is a graduate of a medical school in the Western Hemisphere which does not have diplomatic relations with the United States. Presently only two countries fulfill this requirement, Nicuaragua and Cuba. The applicant must have received a medical education which was similar to that received by a U.S. medical graduate at the same time, but it will be difficult to ascertain the similarity of educations for someone who graduated from a school in one of those two Latin American countries ten or twenty years ago.

The applicant must have resided in Florida for three or more years before applying and must have legal immigration status here. He has two examination choices: the first, he could take and pass the ECFMG or FMGEMS test, or he may enroll in a course, which will be given by the University of Miami School of Medicine which will prepare him, in his native language, to take the special Florida Board Examination. The special course, 10 months in duration, will be set up along the guidelines written by the Legislature in 1974 in statute 74-105. That legislation established the course and a Spanish language licensure examination for Cuban refugee physicians.

Section 5(b) applies to older refugee physicians, who passed the old University of Miami course, given prior to January 1, 1982. These individuals can take

the Florida Board Examination, without having to attend the course again.

Subsection (e) discusses the fact that the Board must translate the examination into any language as long as five or more candidates request the translation and is willing to pay for the translation. Since the Restricted license statute and the Florida Board examination apply only to nations in the Western Hemisphere without diplomatic relations with our country, it is likely that only Spanish translations will be allowed.

Subsection (f) demands that the Medical Board give the first sitting of the examination no later than February 2, 1987, less than eight months after the Legislature met to enact the law. This will not allow enough time for the more recent graduates of schools in these designated nations to take the one year preparatory course at the University of Miami, and so candidates for the first few examination sittings will be the older Cuban physicians who qualified under 74-105, and subsection 5.(b) of the new law, who took the prior course given by the University before January 1, 1982.

Upon completion of the course and passage of the examination in their native language, these candidates will be issued a Restricted medical license which will allow them to practice medicine in Florida for one year under the direct supervision of another licensed physician. If at the end of one year, they have no malpractice suit and no other derogatory information against them, the license will become a regular unrestricted Florida medical license.

It has been the tendency of all state medical boards over the past decade to standardize the licensure and examination process, and especially to do away with special categories of licensure that allow less than fully qualified individuals to obtain a license. This section, creating a Restricted license in Florida and allowing that license to become permanent and unrestricted after just one year of supervised practice by any other physician, regardless of what that other physician's qualifications are, is highly regressive and subjects physicians in this state, and their patients, to a double standard of licensure based on so weak an argument as to whether the physician attended medical school in a nation which presently has no diplomatic relations with the United States.

These applicants will not have to be certified by the EDFMG; will not have to take the FMGEMS test; will not have to serve a residency PGY I at an approved hospital program; and will not have to pass the regular state licensing examination, the FLEX. They will merely have to take a preparatory course in their native language and pass a special state examination in their native language.

- Dr. Feinstein, 3661 S. Miami Ave., Suite 1002, Miami 33133.

Motrin® 800 mg TABLETS
ibuprofen



Extra strength
Convenience
Economy

Upjohn
A Century of Caring
1886·1986

©1986 The Upjohn Company

J-6138 January 1986

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

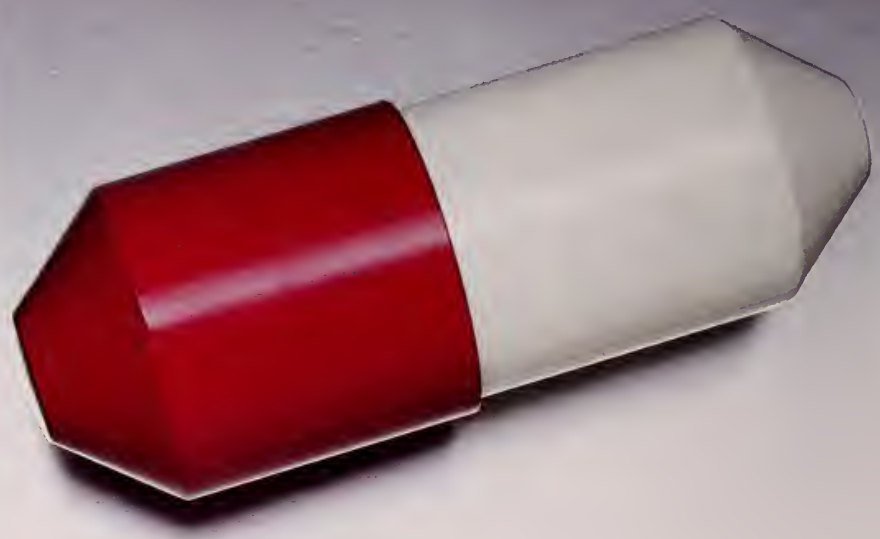
Supplied: **'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

BRS-DZ.L42

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions)



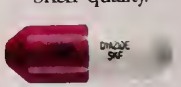
Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 20 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.

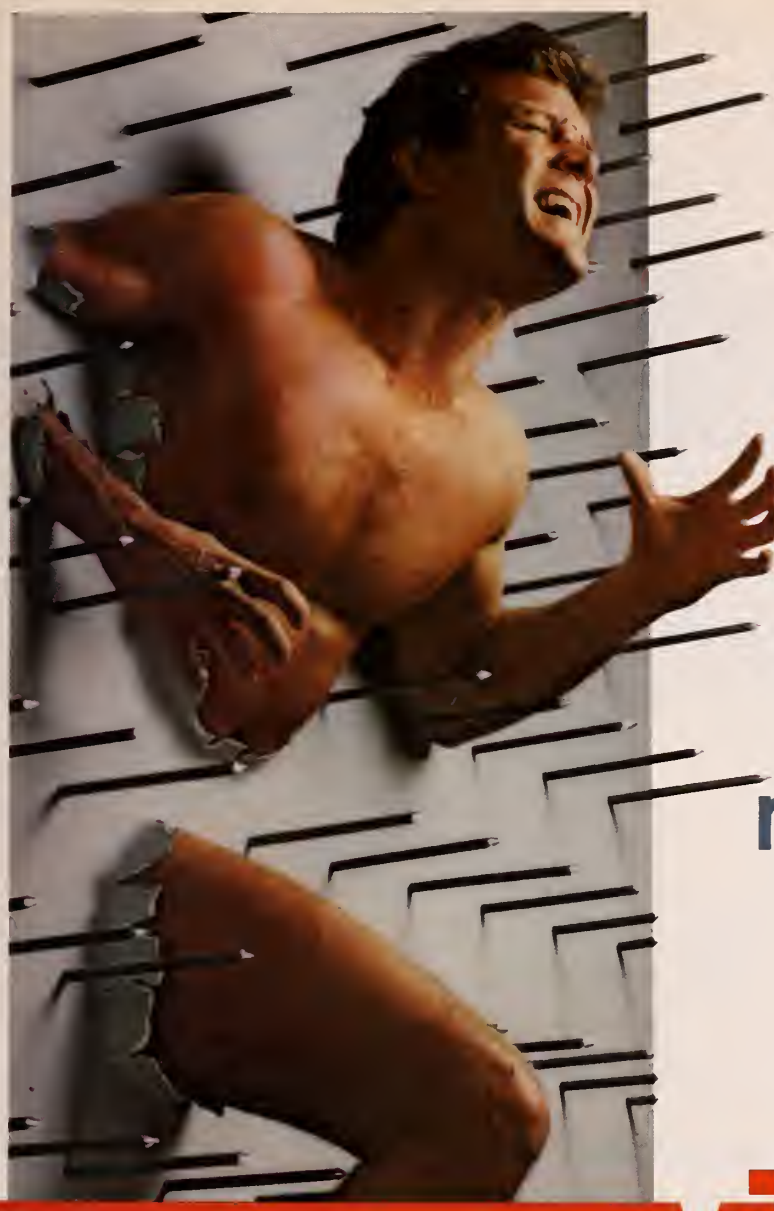


a product of

SK&F CO.

Carolina, P.R. 00630

©SK&F Co., 1983



To dull the point of moderate to moderately severe pain...

vicodin® III

hydrocodone bitartrate 5 mg (Warning: May be habit forming.)
with acetaminophen 500 mg

Brief Summary

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS
Drug Abuse and Dependence: VICODIN is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics, therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982

KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

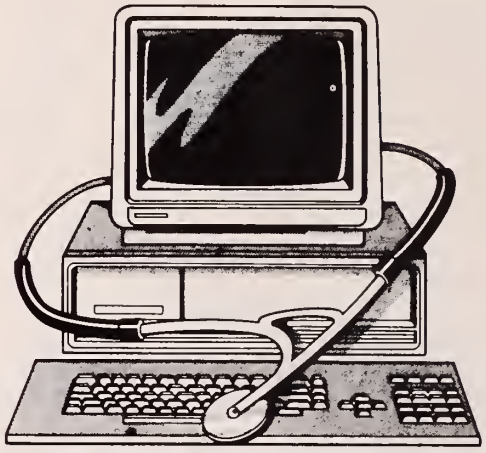
5725

February, 1985

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

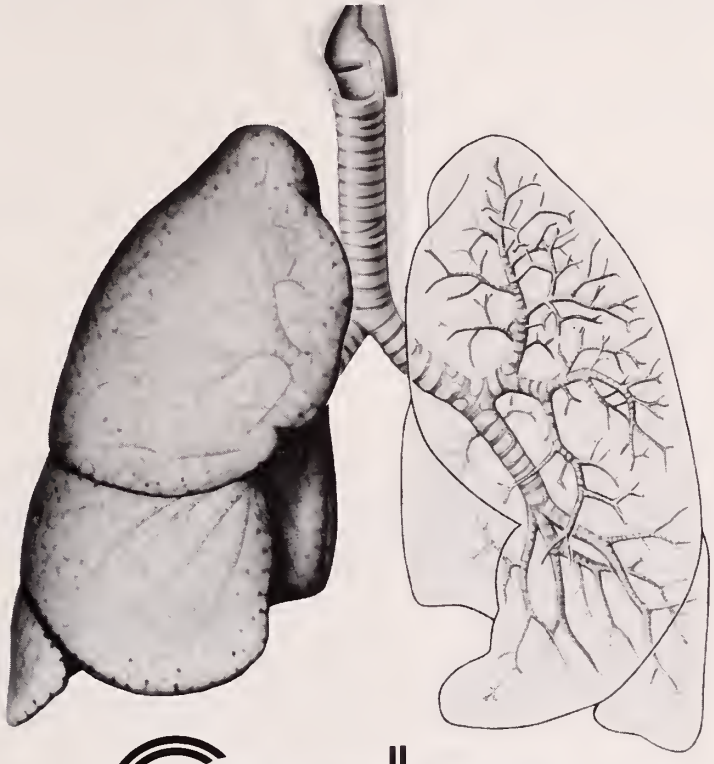
Address

City State Zip

Specialty () Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, H influenzae, Streptococcus pneumoniae, Streptococcus pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

© 1986, ELI LILLY AND COMPANY [060485LR]

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

600332

U.S. Postal Service

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

Required by 39 U.S.C. 3685)

1A. TITLE OF PUBLICATION	1B. PUBLICATION NO.	2. DATE OF FILING
The Journal of the Florida Medical Association, Inc.	2 8 4 2 8 0	Oct. 1, 1986

3. FREQUENCY OF ISSUE	3A. NO. OF ISSUES PUBLISHED ANNUALLY	3B. ANNUAL SUBSCRIPTION PRICE
Monthly	12	$15.00

4. COMPLETE MAILING ADDRESS OF KNOWN OFFICE OF PUBLICATION *(Street, City, County, State and ZIP+4 Code) (Not printers)*

760 Riverside Avenue (P. O. Box 2411) Jacksonville, FL 32203

5. COMPLETE MAILING ADDRESS OF THE HEADQUARTERS OF GENERAL BUSINESS OFFICES OF THE PUBLISHER *(Not printer)*

760 Riverside Avenue (P. O. Box 2411) Jacksonville, FL 32203

6. FULL NAMES AND COMPLETE MAILING ADDRESS OF PUBLISHER, EDITOR, AND MANAGING EDITOR *(This item MUST NOT be blank)*

PUBLISHER *(Name and Complete Mailing Address)*

Florida Medical Association, Inc., P. O. Box 2411, Jacksonville, FL 32203

EDITOR *(Name and Complete Mailing Address)*

R. G. Lacsamana, M.D., P. O. Box 2411, Jacksonville, FL 32203

MANAGING EDITOR *(Name and Complete Mailing Address)*

Camille H. Crabtree, P. O. Box 2411, Jacksonville, FL 32203

7. OWNER *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Item must be completed.)*

FULL NAME	COMPLETE MAILING ADDRESS
Florida Medical Association, Inc.	P. O. Box 2411, Jacksonville, FL 32203

8. KNOWN BONDHOLDERS, MORTGAGEES, AND OTHER SECURITY HOLDERS OWNING OR HOLDING 1 PERCENT OR MORE OF TOTAL AMOUNT OF BONDS, MORTGAGES OR OTHER SECURITIES *(If there are none, so state)*

FULL NAME	COMPLETE MAILING ADDRESS
NONE	

9. FOR COMPLETION BY NONPROFIT ORGANIZATIONS AUTHORIZED TO MAIL AT SPECIAL RATES *(Section 423.12 DMM only)*
The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes *(Check one)*

[X] (1) HAS NOT CHANGED DURING PRECEDING 12 MONTHS

[] (2) HAS CHANGED DURING PRECEDING 12 MONTHS

(If changed, publisher must submit explanation of change with this statement.)

10. EXTENT AND NATURE OF CIRCULATION *(See instructions on reverse side)*	AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NO. COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
A. TOTAL NO. COPIES *(Net Press Run)*	15,800	15,800
B. PAID AND/OR REQUESTED CIRCULATION 1. Sales through dealers and carriers, street vendors and counter sales	------	------
2. Mail Subscription *(Paid and/or requested)*	15,397	15,306
C. TOTAL PAID AND/OR REQUESTED CIRCULATION *(Sum of 10B1 and 10B2)*	15,397	15,306
D. FREE DISTRIBUTION BY MAIL, CARRIER OR OTHER MEANS SAMPLES, COMPLIMENTARY, AND OTHER FREE COPIES	181	186
E. TOTAL DISTRIBUTION *(Sum of C and D)*	15,578	15,492
F. COPIES NOT DISTRIBUTED 1. Office use, left over, unaccounted, spoiled after printing	222	308
2. Return from News Agents	------	------
G. TOTAL *(Sum of E, F1 and 2–should equal net press run shown in A)*	15,800	15,800

11. I certify that the statements made by me above are correct and complete	SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER, OR OWNER
	Camille H. Crabtree, Managing Editor

Messages from Machiavelli

Physicians play the role of the ingenue in the ongoing saga that is politicizing and corporatizing medicine. Naivete garnished with apathy paralyzes our decision making processes. We are beset with difficult challenges but we respond to these with inaction or feeble defenses. Rarely have we physicians proposed, passed, and actuated any novel scheme that might answer the medico-social needs of today's society. Our training and experience cripple our ability to successfully navigate the labyrinthine machinations of political and corporate America.

What are we to do? Frequently the answers to the most convoluted contemporary problems reside in the observations and writings of antiquity. Readings of Cicero, or Livy, or Xenophon reveal a startling similarity between the instincts and behavior of today's politicians with their political ancestors of Greece and Rome. Today's political maven is a replicate of his ancient counterpart except that the business suit has replaced the toga.

Any study of the political process should include several readings of Niccolo Machiavelli's *The Prince.*[1] Prior to Machiavelli, many had written of politics and government and had rendered histories of strong or ineffective leaders. But none before him had attempted to author a self-help manual of political power.

Machiavelli was a funtionary in the Florentine Republic. The times in which he lived (1469-1527) were politically tumultuous and resulted in the fragmentation of the Italian peninsula into a medley of city-states. The struggle for dominion in Italy was fought by the kings of Spain and France, the church, families such as the Medicis and Borgias and by the individual city-states themselves. The success of any one faction was ephemeral and turnover of the power structure was repeated with regularity. Machiavelli was an assistant to the chief magistrate of Florence. He represented Florence in many diplomatic missions, both in Italy and abroad. He was a keen observer and recorder of the power process and a sensitive and accurate assessor of the sources and strengths of the power elements in any political situation. Unfortunately, in 1512, the Florentine Republic was overthrown by an alliance of the Spanish, Swiss and Cardinal de Medici. Machiavelli was banished from Florence and, while in exile, wrote *The Prince* to Lorenzo de Medici as an attempt to win notice from the Medicis and to regain political appointment — goals which he achieved.

For centuries Machiavelli has been indicted as an amoral, ruthless powermonger. Educated people recognize the existence and gestalt of *The Prince* but few have read it. The book is a candid collection of his observations, studies and conclusions about the effects of the deportment of rulers upon their success or failure in acquiring and maintaining control. Physicians who wish to regain and maintain control over medicine could derive many lessons from this treatise.

As with all classical works, the lessons discovered centuries ago can be applied to any modern ear. Similarly, Machiavelli's doctrine can (with a moderate dose of literary license) be transmuted from the political intrigues of 15th century Italy to the upheavals of medicine in the 1980s. Allow me to formulate a current day exegesis of his work to the format of 1986 medicine.

Lesson one — comments pertinent to the apathy and passivity of physicians in the face of the current medical malaise • Machiavelli admired the Romans for their ability to predict and assess changes and to respond to threats while they were still controllable.

". . . the Romans . . . (like) wise princes . . . (had) regard not only for existing disorders but for future ones as well, avoiding them with all possible diligence. By making provision in advance, princes may easily avoid such difficulties . . . Thus the Romans,

foreseeing difficulties, always remedied them. And they never allowed them to persist in order to avoid a war for they knew that wars cannot be avoided and can only be deferred to the advantage of others."

The attitudes of most physicians is one of passivity rather than aggression towards medicine's problems. Doctors frequently fail to predict and assess the magnitude of the storm until it is lashing about them. Today's adversities threaten medicine more heavily than those that appeared in other parts of this century. Yet many physicians respond to the threats of HMOs, PPOs and government infringement only with complaints but no action. They fail to involve themselves in the political process either directly by trying to influence their legislators or indirectly by means of encouraging their patients to influence the legislators. Many even fail to financially support the county, state and national medical associations.

Florida physicians have recently been burdened by the 1986 pharmacy law in which incredibly unnecessary paperwork has been imposed on physicians who want to distribute drug samples. Furthermore, any physician who distributes medicine for a fee from his office must complete six hours of pharmacological CME credit each year to maintain that right to distribute medicine. Obviously the implied threat of this legislation is to totally deprive physicians of the right to either dispense samples or sell medications. Physicians as a group need to develop a suitable response to these threats now, rather than await the onset of the spring legislative season.

When physicians do respond aggressively to a crisis they frequently succeed. For instance, when International Medical Centers moved into Palm Beach County during the presidency of Lee Fischer, M.D., the medical society vigorously responded to the marketing campaign of IMC with a public relations campaign of its own. The doctors educated the public about the limitations and disadvantages of the HMO and successfully repulsed IMC's attempt to gain a foothold in Palm Beach County. Physicians in central Ohio have also prevented the establishment of several national HMOs in their area by similar strategems.

Lesson two — concerning factions and the weakness which they promote ● Machiavelli wrote, "I do not believe that factions ever do anyone good. In fact it is inevitable that a city divided by factions will fall quickly to any approaching enemy. The weaker side within will ally itself with the invader and the stronger side will not be able to hold out alone."

American physicians have splintered themselves into multiple specialty and subspecialty groups, each with its own goals and, of which many conflict with one another. Despite our desperate need for unity and cohesion, the majority of physicians refuse to support a single organization. Over half the doctors do not belong to the American Medical Association. Such factionalism will ultimately dissipate our ability to control medicine.

Factionalism enabled the British government in 1948 to socialize medicine in that country. The government calculated that their medical program would be defeated by a united stand by the physicians. So they bought off the specialists with promises of fee schedules higher than those paid to the general practitioner and a monopoly on in-hospital patient care. The specialists accepted the gambit. The specialists and general practitioners became divided in their resistance to the government scheme and socialized medicine was imposed to the detriment of both groups.

Over half the doctors do not belong to the American Medical Association. Such factionalism will ultimately dissipate our ability to control medicine. Factionalism enabled the British government in 1948 to socialize medicine in that country.

Factionalism also arises from the over-exuberance and competitiveness of hospital administrators. This competition has encouraged some hospital administrators to promote strife and divisiveness among doctors living within a single community. Some such medical communities have fractionated themselves into different competitive groups with each hospital serving as the rallying point for each group's activities. In such circumstances the hospital administration rather than the community physicians controls medicine. Sometimes the hospital administration will attempt to create PPOs or HMOs that directly compete with and undermine fee schedules of physicians. If physicians, who oppose the establishment of such prepaid vehicles of medical care in the community, would unite, they could undercut the power of such an administration. A few weeks' period during which the patients' census at the offensive hospital is reduced by diverting patients to rival institutions will, as it has in some areas, dissolve the adminstration's power over the physicians and erase the establishment of an HMO or PPO.

Similarly, our dealings with the federal government and state governments require a unified voice in medicine. Every doctor needs to belong to a state and national medical association. We need universal membership in the American Medical Association so that we can all agree on common goals for medicine and a common methodology in achieving them. With unification through our medical societies we can mount a much more powerful and productive answer to the forces that are extirpating the control of medicine from the physician.

Lesson three — on the fallacy of resigning control of one's medical career to a hospital, HMO or other key administrator ● ". . . we may extract the general rule

which scarcely ever fails. He who causes another to become powerful ruins himself. . .''

Medicine confers many benefits to the physician, but perhaps, the most precious is the power to enjoy the personal independence it allows. Physicians enjoy the independence to select the specialty of their choice; to pursue a multitude of careers as practitioners, teachers, researchers, scholars, administrators and politicians; to adjust their income levels in a limited fashion by their choice of specialty or by altering the intensity of their work schedule; to select a geographic area in which to practice their skills; and to control the style and quality of their practice. Obviously this freedom has been bridled by the regulations that applied to their career choices. The researcher is limited by the wishes of the granting agency and the rules of the institution in which he works; the author by the opinions of the editorial staff; their income levels by the demographics and socioeconomic status of the area in which they settle, etc. Perhaps the private practitioner experiences the greatest freedom but practitioners are resigning their freedom by indenturing themselves to HMOs, PPOs and in some areas, to the local hospital administrators. By contracting themselves to such organizations doctors not only surrender earning capacity but ultimately their control over professional decision making regarding their patients.

It is the physicians' moral, ethical, intellectual and scientific obligation and right to manage the medical needs of each individual patient. In opposition to this, it is the goal of HMOs and PPOs to massage their bottom lines.

It is the physicians' moral, ethical, intellectual and scientific obligation and right to manage the medical needs of each individual patient. In opposition to this, it is the goal of HMOs and PPOs to massage their bottom lines; to accomplish this successfully, many HMO and PPO contracts severely restrict the participating physicians access to or selection of consultants, diagnostic tests or right to hospitalize. The medical care decisions which should be the sole province of the physicians are compromised and surrendered to the corporation. The physician loses his power. He no longer is the leader of the medical care process but demotes himself to the role of an impuissant functionary. As a functionary he resigns part of his professional preeminence. With time the doctor becomes identified as an unexceptional member of the medical care team rather than its dynamic and knowledgeable leader. The value of his training, scholarship and experience becomes deflated in the minds of the patients and the members of the health care team and his prestige and remuneration collapse. The scenario has been repeated in all the Western countries that have socialized medical programs. In each, physicians' leadership was resigned or rapaciously seized by the government. In the U.S. we face a similar attempt to usurp our leadership role, not only by government but also by insurance companies, HMOs and PPOs.

Lesson four — on the recent successes of alternative systems of medical care delivery and the future difficulties such systems will confront • Medicine has enjoyed its present structure for nearly 70 years. Physicians, practicing alone or in small groups, and within the confines of a community hospital, have delivered a scientifically more sophisticated and biologically more beneficial form of health care that has made American medicine technologically the finest ever conceived. Why do some Americans who have been the beneficiaries of this system want to change it? Certainly medicine's high cost and its inaccessibility are reasons for desire for change. But there is a proclivity for change in the power structure that is innate to man.

''Changes of authority come about from a natural hazard which exists in several . . . principalities: that is from the willingness of men to change one lord for another, believing thus to improve their lot. For this reason they take arms against their ruler; but in this they deceive themselves, for experience will prove that they will actually have worsened their lot.''

Thus it is hardly unexpected that politicians and the people they represent will attempt to remove control of medicine from physicians. The miracle is that physicians have sustained control for so long within this country. However, if the control of medicine is wrenched away from physicians, then the new power structure faces even more difficult challenges.

''It must be realized that there is nothing more difficult to plan, more uncertain of success or more dangerous to manage than the establishment of new order. . . for he who introduces it makes enemies of all those who derived advantages from the old order and finds only lukewarm defenders among those who stand to gain from the new one. . .people are by nature changeable. It is easy to persuade them about some particular matter but it is hard to hold them to this persuasion.''

Already cracks in the structure of several HMOs and PPOs are appearing. Some small HMOs are going bankrupt and being overtaken by large ones. Some insurance companies such as Cigna are finding that the medical care business is not as profitable as they had projected. Some other companies such as Humana have been experiencing record financial losses in recent quarters. HMOs find that patient loyalty is lacking and patients rapidly jump from plan to plan in successive enrollment years. Of course, the federal government is attempting to extricate itself

totally from health care by emasculating the Medicare system.

Lesson five — on the failure of some physicians to grasp the significance of the current socioeconomic stresses ● Many physicians demonstrate little interest in participating in the efforts to arrest the upheaval of the medical care system in the United States. Some assume that they can continue to pursue medicine in their own individual manner with minor distortions or interruptions of their practice styles. Others react totally fatalistically — feeling utterly powerless to stifle or alter the form of the tidal wave of change threatening to inundate us. Most physicians wistfully desire medicine to adapt to the ideal of which they conceptualized it prior to entering medical school. Self delusion is a faculty common to man in all ages of history.

"Many men have imagined republics and principalities that never really existed at all. Yet the way men live is so far removed from the way they ought to live that anyone who abandons what is for what should be pursues his downfall rather than his preservation; for a man who strives after goodness in all his acts is sure to come to ruin, since there are so many men who are not good."

Many ethicists have skewered Machiavelli for publicizing these observations and for his subsequent comments that stress that a successful prince must practice good or evil according to the dictates of the moment. Although the personal or professional ethics of the medical practitioner cannot abide an "end justifies the means" standard, Machiavelli's observation on the behavior of government leaders applies in the 20th century as it did in the 16th. In a subsequent chapter in his book he further comments upon the perfidy of government leaders: "How praiseworthy it is that a prince keeps his word and governs by candor instead of craft, everyone knows. Yet the experience of our own times shows that those princes who had little regard for their word and had the craftiness to turn men's minds have accomplished great things and, in the end, have overcome those who govern their actions by their pledges."

Again, physicians must act with a different ethic but any reading of the daily newspaper reveals how timely his comments of the 16th century are to our current age and our current government leaders. Awareness and attentiveness to these behavioral patterns of political humans should arm us with a sceptical mind set during our negotiations and transactions with government and make us wary of any long term commitment by government to any agreement with medicine.

Lesson six — on depending upon popular approval to sustain our future control over medicine ● Physicians are devoid of the traditional sources of power such as the power to tax, to trade legislative favors, or to wield military or economic prowess. As we discussed in previous essays in this series on medical economics, the physician's only current source of power is the people he serves. Machiavelli recognized the importance of winning the support of the populace: "But the prince who comes to power through the support of the people will stand alone and there will be few or none at all near him who will not be disposed to obey him . . It should also be noted that a prince can never be secure against a hostile populace . . (and) that the goodwill of the people is vital to a prince; otherwise he will be helpless in time of adversity."

Obviously we must continue to win our patients' support for the ideals of medical practice to which we adhere. We will have to publicize these ideals and explain their advantages thoroughly or we will forfeit the privilege of practicing according to these ideals. Similarly, we will have to use the media and other forms of communication to convince our patients of the potential harm that they possibly will experience from forms of medical care which we deem inappropriate.

Maintaining the loyalty of our patients requires a lot more than slick public relations. It will involve much greater physician involvement in producing solutions to American medical care problems. Doctors must acknowledge, address and experiment with novel methods of practice to reduce the high cost of medical care. We must develop and promote an indigent care system that is not self serving but truly responsive to the mutual needs of the patients' financial resources and the principalities of quality medical care.

Lesson seven — on the need to develop a physician-politician class of individuals to promote the economic welfare of medicine ● The number of physicians who involve themselves in community activities, and local, state and national politics is pathetically minute. As a result we have deprived ourselves of the ability to bend the laws towards our own interest. Thus we have not been able to resolve the malpractice crisis, avoid the unfairness of the Medicare freeze, or to prevent the increasing interference of PROs into our patient care decisions. Rather than involving ourselves directly in the political process, we have depended upon the goodwill and support of lobbyists and legislators. At times we have had to purchase this support through our political action committee funds and through donations of time and money to candidates favorable to our ideology. In other words, we depend upon mercenaries to conduct our legislative battles. Machiavelli vigorously rejected the dependence upon mercenaries as "useless and dangerous . . . any ruler who keeps his state dependent upon mercenaries will never have real peace or security . . . Mercenaries have no tie of devotion (and) . . . that no state, unless it has its own

arms, is secure. Indeed it is a hostage to fortune, having no trustworthy power to defend it is adversity."

The current physician overflow should encourage medicine to commit resources to the recruitment, training and support of a moderately large coterie of politically adroit people. The legal profession has supported its members who pursued political careers. Doctors should emulate lawyers in this one area.

Medicine's "arms" and "security forces" might be provided by the "doctor-legislator" — an individual who totally devotes himself to the legislative process. He must never turn his attention away from (legislative) "exercises." Obviously such a committed physician-legislator is a member of a rare and endangered species. The current physician overflow should encourage medicine to commit resources to the recruitment, training and support of a moderately large coterie of politically adroit people. The legal profession has supported its members who pursued political careers. Doctors should emulate lawyers in this one area. Perhaps the local county medical societies could support one candidate each year for the state legislature and the national AMA could support candidates for Congress. The M.D. degree need not be a requirement for the medical legislators. Spouses, children or other people with an intimate knowledge and respect for the American medical tradition could become members of this group.

Summary • Machiavelli's reputation as the apologist for ruthless tyranny would not seem to recommend his work as a political resource text for physicians. Despite his cynical views of rulers and the ruled, his observations on human political behavior are as fresh today as they were 470 years ago. Careful readings of and reflections upon his work will provide starkly realistic insights into the political process and help correct the ingenuous disposition towards politics that abides within doctors because of our idealism and political inexperience.

Reference

Machiavelli, D.: The Prince, Translated by Daniel Donno, Bantam, Toronto, 1966.

Jacques R. Caldwell, M.D.
Daytona Beach

"Deafness is something you put beside you not in front of you."

LINDA BOVE / ACTRESS



PHOTO: HELEN NESTOR

Linda Bove performed with The National Theatre of the Deaf for nine years. She has also starred in the Tony Award winning show, *Children of a Lesser God*.

Believe in them. Break the barriers.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, WASHINGTON D.C. 20210

PRODUCED BY THE SCHOOL OF VISUAL ARTS PRESS, LTD

FLORIDA MEDICAL
DEPARTMENTS
- ☐ NOTES & NEWS, 795
- ☐ DEAN'S MESSAGE, 796
- ☐ ENCORES!, 797

NOTES & NEWS

ACP physicians network to monitor community medical practices

The American College of Physicians (ACP), the nation's largest medical specialty society, has been awarded $171,059 for planning a network of College members to determine how practicing clinicians actually use medical resources to diagnose and treat selected clinical problems seen in ambulatory care settings. ACP will plan the Physicians Network during the 15-month period from September 1986 through November 1987, with support from the Henry J. Kaiser Family Foundation of Menlo Park, California.

According to John R. Ball, M.D., J.D., F.A.C.P., Executive Vice President of the College, "The prospective data collected via the network will be used to identify optimal patterns of care so that we can develop guidelines for maintaining and improving patient care while containing the cost of such care."

The Physicians Network was initially outlined in 1981 by J. Sanford Schwartz, M.D., who served as first director of the College's technology assessment program — CEAP (Clinical Efficacy Assessment Project) — from 1981 to 1983. "In conjunction with CEAP," said Dr. Schwartz, "the Physicians Network will be a major program to improve clinical practice." Dr. Schwartz is an assistant professor of medicine, senior scholar in epidemiology and senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania and is experienced in collecting survey data from practicing physicians. He will be assisted in the planning stages of the project by Alvin I. Mushlin, M.D., Sc.M., F.A.C.P. and Harold C. Sox Jr., M.D., F.A.C.P.

"CEAP evaluations are based on data that are recorded in the literature — data obtained from controlled studies at academic medical centers," said Dr. Schwartz. "Unfortunately, we have very little information on the actual use and effectiveness of technologies in community practice," he said. Because most medical care is delivered in ambulatory care settings in the community, ACP needs to learn more about how and why physicians decide to use specific tests or procedures in these settings. Added co-investigator Dr. Mushlin, who is associate professor of medicine in the division of general internal medicine at the University of Rochester, "The Physicians Network will be designed to prospectively collect data on practice patterns and show us what diagnostic tests, procedures, and referrals lead to the best possible patient care."

The College will use the information generated by members of the network to determine the frequency of use and costs associated with diagnostic tests, procedures, and referrals; measure the variation in usage of these elements of medical practice; and determine their effects on patient care. "Establishing and using a network to collect this data," said Dr. Mushlin, "will provide the College and other interested parties the information that is needed for designing effective educaitonal strategies to correct test misuse, developing new methods to improve the clinicians' interpretations of various tests, and identifying areas where new tests might be particularly useful."

During the initial phase of the 15-month planning project, the team will refine the objectives of the study, outline an administrative structure for the network, identify clinical problems that could be addressed by such a network, and design one or two studies. The ACP Clinical Efficacy Assessment Subcommittee will serve as the oversight committee for this project. The second phase will be a feasibility study to develop and test data-gathering instruments. During the last phase, the project team will refine their findings from the initial and second phases for the development of a comprehensive plan for a functioning Physicians Network.

Dr. Mushlin brings to the project expertise in developing and testing clinical strategies for addressing common problems in internal medicine. He has developed and tested an outcome-based system for quality assurance in ambulatory care that examined how the use of various tests affects patient welfare. Dr. Mushlin, who was a founder and council member of the Society for Research and Education in Primary Care Internal Medicine (SREPCIM), currently serves on the health care technology study section of the National Center for Health Services Research.

As professor of medicine and chief of the division of general internal medicine at Stanford University School of Medicine, Dr. Sox is well-versed in the empirical elements of clinical decision making. He is a past president and council member of SREPCIM and presently serves on the College's Clinical Efficacy Assessment Subcommittee.

During the 15-month planning phase, these principal investigators will collaborate with Lincoln Moses, Ph.D., professor of statistics at Stanford

University; John Ware, Ph.D., of the University of California at Los Angeles and the Rand Corporation; and Anita Stewart, Ph.D., of the Rand Corporation to outline the actual design of the network and determine the data collection tools that will provide the College with the most accurate and useful information. Drs. Moses, Ware, and Stewart will provide expertise in statistics, longitudinal study design, and outcome measurement.

Exercise testing report released

A special report entitled "Guidelines for Exercise Testing" has been released by the American College of Cardiology (ACC) and the American Heart Association (AHA). The report, developed by an ACC/AHA Task Force on Assessment of Cardiovascular Procedures, sets down the indications and contraindications regarding the appropriate use of exercise testing in the diagnosis and treatment of patients with cardiovascular disease.

Published in the September 1986 issue of the *Journal of the American College of Cardiology*, the report classifies the indications for exercise testing as follows:

Class I. Conditions for which there is general agreement that exercise testing is justified.

Class II. Conditions for which exercise testing is frequently used but in which there is a divergency of opinion with respect to value and appropriateness.

Class III. Conditions for which there is general agreement that exercise testing is of little or no value, inappropriate or contraindicated by risk.

Chairman of the ACC/AHA Task Force is Charles Fisch, M.D., Indianapolis, and Robert C. Schlant, M.D., Atlanta, is chairman of the subcommittee which developed the report. The first report of the Task Force was published in 1984 and was titled "Guidelines for Permanent Cardiac Pacemaker Implantation." The third report, entitled "Guidelines for Clinical Use of Cardiac Radionuclide Imaging," will be published in December 1986. As each procedure is examined in detail, a subcommittee of from 10-15 physicians and scientists is appointed to draw up recommendations relative to that particular procedure.

Reprints of the reports are available from Mr. David J. Feild, Assistant Executive Vice President, ACC, 9111 Old Georgetown Road, Bethesda, MD 20814.

ACC, a 14,820-member nonprofit professional medical society and teaching institution, is dedicated to ensure optimal care for persons with cardiovascular disease or those with the potential for developing cardiovascular disease and, through educational and socioeconomic activities, to contribute significantly to the prevention of cardiovascular disease.

DEAN'S MESSAGE

The Flexner report and the issue of faculty roles

In these remarks an attempt is made to briefly focus on our inability to distinguish among faculty roles in our contemporary medical schools and the relation of this difficulty to the Flexner report of 1910.

This landmark document on medical education found that there was an enormous overpopulation of uneducated and ill-trained medical practitioners from the commercial schools of 19th century America. It also pointed out that the universities had failed to appreciate the great advances in medical education being made in Europe, especially with respect to the scientific basis of medicine.

Medical historians in their analysis of the Flexner report have believed that this report was based on the amalgamation of the European patterns of medical education and that of the Johns Hopkins Medical School. In reality, the Flexner report used essentially two models of education, that is those of the German Medical University System and the clerkship pattern of the hospital-based schools of the University of London. It is important to realize that these two systems represented the two extreme points in the range of educational premises and objectives. The German system was built on the premise that because of the increasing specialization of the future, training and development of a physician starts not before, but after graduation from medical school. The curricular strategy, therefore, must prioritize on developing a broad and massive scientific base on which a specialty training may most appropriately be built in the subsequent years of graduate medical education. In addition, the German Medical University System has always been targeted for an elitist education unconcerned by considerations of rates of attrition. Conversely, the central premise of the hospital-based medical schools of London was that medical education must become intimately, continuously, and inextricably related to the delivery of medical care in teaching hospitals, and the graduating senior must be viewed as a physician capable of taking care of the sick on the very day of leaving school.

A combination of these two approaches to medical education represents a misfit or a mismatch carrying a conceptual flaw in the development of a medical school. This conceptual flaw could be identified as a lack of distinction of faculty roles. It is this inability of our contemporary schools to distinguish between faculty roles why I find it important to bring this issue up in this article. The practical consequences of this inability every year lead to

a considerable dilemma in the evaluation of faculty for promotion and/or tenure and also creates confusion about the philosophy guiding our recruitment approaches of new faculty.

A better definition of this dilemma could be stated as follows. Implemention of Flexner's recommendations, proceeding slowly for the following two decades and accelerating rapidly after World War II, made America a leader in medical education and research in the developed world. The salient feature of this development was the unprecedented expansion of federal support for biomedical research after World War II. This massive research support became a subsidy for medical education. This enormous growth in biomedical research has significantly affected the nature of medical education and the goals and priorities of the medical school faculty. Less emphasis was given to teaching, and more to the research process and to recruiting faculty whose major interest and skills were in biomedical research. It was argued that the conduct of research improves the quality of the teaching. The full-time faculty of the clinical departments were now perceived as different from the skilled practitioners who devoted all their time to patient care within and outside the hospital. The latter type of practitioner gradually became alienated and "second rate" in the value structure of the medical school. I believe this view could be most appropriately characterized by a statement of George Bernard Shaw's "Man and Superman" in which he says that, "He who can, does. He who cannot, teaches."

One would suspect that it would be unnecessary to dwell at any length on differences between activity in the academic and practice spheres. But my annual review of the tenure and promotion considerations as well as conversations with many of our colleagues have convinced me that there is a tendency to blur the distinction between these roles, in part because such distinction might be divisive, but in larger measure, I suspect, because inability to encompass the fullness of both within our individual competence, is somehow viewed as an admission of inadequacy. Nevertheless, there remain important differences between health care delivery and clinical science, between the demands of each, and between the aptitudes and characteristics of those who work in these two fields. Only by recognizing these distinctions, acknowledging that which is unique about each, can any cooperation or partnership be productive. For it is precisely difference which brings to a union that which makes it fruitful.

We are dealing with three basic functions — patient care, teaching, and research. There are evident areas of interaction between the three and it is precisely these which are most significant to us. It is between the two major areas of interaction, i.e., teaching-research and patient care-teaching that tension most often occurs. It is my thesis that such tension is inevitable and that, rather than unhealthy, it can be productive of harmony.

Some of us are predominantly practitioners, some of us predominantly health scientists. In our daily lives and in our professional value systems we personify the differences and demands described. In tenure and promotion considerations, therefore, it is necessary to examine each case on its own merits, that is to determine what is the value of a faculty member in the overall scheme of things of the institution whether such contribution is in teaching, research or service. The faculty member should be found acceptable as long as he or she possesses outstanding qualifications in any area of the academic triad. Our concern is to define a productive working relationship which affirms the validity of each. On the other hand, the quality of that contribution must be deemed nothing less but excellent in order to justify the continued presence of that individual on our faculty. The same considerations should apply to faculty recruitment.

Andor Szentivanyi, M.D.
Dean of the College of Medicine
Deputy Vice President for Medical Affairs
University of South Florida
Tampa

ENCORES!

Bread upon the waters

Americans respect physicians but do not seem to like them very much. Everyone makes an exception for his own physician(s), of course, but physicians as a group are viewed far less favorably. Organized medicine is seen as existing primarily to serve the economic and political interests of its physician-members. The AMA, for example, is probably most widely remembered for its opposition to Medicare over twenty years ago; and to most of the elderly Medicare is a godsend.

Most Americans' major health concerns (if they are not seriously ill) involve the size of their health insurance premiums and fear that health-related expenses not adequately covered by their plans will damage them economically. They are just not very sympathetic to the economic and professional woes of physicians who in any event are going to make what they view as a lot of money. Fees for hospitalization and for major surgical procedures in particular are simply staggering to many people, especially the "working poor" struggling to make ends meet, and

the elderly who do not have enough to make Medicare copayments for treatment of major illnesses.

The media's portrayal of physicians is also two-sided. Individual physicians, especially those doing research, performing a community service, or perhaps introducing some innovative therapeutic advance, are accorded great respect and portrayed sympathetically. But the media loves to portray physicians as a group quite differently: we are often shown as greedy, uncaring, elitist, and arrogant. Every attempt by the profession to defend itself against the endless series of legislative, economic, and regulatory assaults mounted against it is publicized as further evidence supporting that portrayal. We cannot win for losing.

The problem is that there is more than a grain of truth in all this. At the FMA House of Delegates meeting in Tampa there occurred a unique event: the House passed a resolution dealing with regulation of off-road recreational vehicles. It produced the only discussion at that meeting directed at the public good rather than the benefit of the medical profession. The AMA meeting in Chicago was pretty much the same. As a group we seem remarkably focused on our own problems, and oblivious to other people's. It is hard to blame the public, and the media, for being oblivious to ours.

If we are not greedy and indifferent, we really ought to be able to communicate that to the public. Simply telling them will not work. Talk is cheap.

It is hard to be altruistic while enduring a state of siege. We doctors now occupy the modern-day psychological equivalent of Vicksburg, Thermopylae, or the Alamo, and tend to be preoccupied with the various kinds of missiles raining into our encampment. Certainly we need to fight even harder to defend the professionalism in our profession from the assaults of those who would use economic leverage to turn it into a sort of cross between a public utility and medical fast-food franchise. But we have to do more; we need the public, our patients, with us instead of against us.

Le me advance a radical proposal: we will do a great deal for ourselves by getting out and doing things for the public with no thought of recompense of immediate gain.

What about buying space in the *Democrat* to talk about AIDS or Chernobyl? What about lobbying the Legislature on important public health issues — not just economic ones? What about a more active role in public health education? What about getting out and going around to schools even more than we are doing now to talk about smoking, drinking, drugs, and seat belts? What about publicizing the missionary work of our members?

As individual physicians we are doing these things; collectively we are not. The reason, of course, is that as a group we need a mechanism for organizing and channeling resources (of both time and money) into public service endeavors.

Unless we serve the public well, the public — and its leaders — will serve us badly.

C. William Applegate, M.D.
President-Elect
Capital Medical Society
Tallahassee

Reprinted with permission from *Cap Scan, The Newsletter of the Capital Medical Society,* No. 145, June 1986.

The dangers of professional pressure

Recently, a prominent Orlando-area physician specialist died by his own hand. His family, his fellow physicians and his community were shocked and devastated.

Certainly he is not the first physician in Orange County to commit suicide. And, unfortunately, he will not be the last.

Other Central Florida physicians who have died from self-inflicted or self-induced means have been outstanding physicians. They have been chiefs of staff of area hospitals. They have been leaders of state societies. They have been esteemed by their peers. They have been, to the outsider, successful, professionally, personally and financially. In short, they have seemed to have those life-features that would normally equate to happiness.

In May, 1965, the American Medical Association began including "suicide" as a cause of death for their physician obituaries. Based on this information, Craig and Pitts (*American Journal of Psychiatry* 136:1059, Aug., 1979) identified 544 male suicides and 41 female suicides out of 18,730 total physician deaths, in a five year period from May, 1967, to May, 1972.

In any one year, thus, 3.03% of male physician deaths will be due to suicide. This figure corresponds to the expected annual suicide rate of other professional men, such as attorneys and dentists.

Likewise, women physicians, who have a threefold increase in annual suicides over the annual population, correspond in suicidal death rates with other professional female groups.

Hence, the often-touted feeling that physicians commit suicide more than other professionals would appear to be a myth.

Male physicians commit suicide most often in the middle years between 45 and 64, with a mean average of 51 years. Female physicians, on the other hand, have a high incidence of suicide during their training years.

In doctors, the method of death is much more likely to be from drug overdose than it is from gunshot. This is in contradistinction to the general population. Such probably relates to the fact that physicians have ready access to drugs and know how to use them.

There is a seasonal variation in suicide occurrence among physicians with there being a reported rise in the spring. And, certain specialties seem more prone to suicide than others, notably psychiatrists, anesthesiologists and otolaryngologists.

What is it about the personality of a physician that makes him or her suicide-prone?

It is known that affective illness is more common among members of the upper class and among officers than enlisted men. Among college students suicide attempts are more common in the best students, and uncommon in poor ones.

It is apparent that attorneys, dentists, and physicians are engaged in activities that are highly independent. Other groups that share this characteristic and in which suicide is proportionally high, but for which we have no data, are brokers, commission salesmen and prostitutes. All these professions are characterized by marked dependence on individual performance, emphasis on individual prestige and frequent rivalry with other persons of the same profession in a setting in which such a rivalry may not be overtly expressed.

Many personality traits that characterized a good physician, attorney, or dentist are also traits that seem to predispose to depression. Among such traits are careful control of emotional expression, compulsive attention to details, conscientiousness and prolonged deferral of gratification.

The extensive training required in effect may result in a series of short-term gratifications followed by long-term privation or loss. The graduating college senior may feel great for the short time until he becomes a lowly freshman medical student. The graduating medical student at last has "arrived" until he begins his internship. After completing his residency the doctor is often depressed by the fact that his fantasies of material and social reward are undercut by the realities of professional competition and economics. The addition of a few losses in such areas as marriage, physical health, economics or important patients may be sufficient to tip the balance toward severe depressive illness.

Mild symptoms may include cynicism, irritability or excesssive work (to compensate for or deny the losses). Depending on other factors, more severe depression may be evidenced by alcoholism, sexual indescretion or dysfunction, use of tranquilizers, barbituates or narcotics. Physiologic malfunctions such as insomnia, bowel disturbances and headaches are common. Fearing further loss of self-esteem, depressed physicians are especially loath to seek personal psychiatric help. Before seeking such help, the physician may compound his problem by self-medication (*New England Journal of Medicine*, 268:1278. June 6, 1963).

Furthermore, physicians deal often with disease, dying and death. They deal, too, with persons who are exposed to severe physical violence. Is it any wonder, then, that some doctors may begin to feel, wrongly so, that death is a way of solving personal problems?

Couple these typical compulsive personality traits and the often depressing nature of our work, with today's current climate of (1) the dwindling physician income; (2) the malpractice crisis; and (3) the intervention of third parties into the control of medicine, and it becomes evident why some physicians all too frequently "give up!"

Fellow physicians, do not despair! In spite of all of this, the medical profession is still the finest in the land. There is no other profession so deeply based in humanitarianism that our every act is an act of kindness, often heroic. This we must never forget.

At a recent memorial service for one of our deceased physicians, Rev. Richard S. Brown, a pastoral counseling consultant for West Lake Hospital, said: "This unfortunate loss of life should make us pause and consider the meaning of life. For there is a terrible tendency on the part of those of us, who are in the helping professions, to become so isolated, so alone, unable to nurture ourselves or be nurtured, perhaps even believing that we are beyond the need of help. We need to humble ourselves from time to time and remind ourselves that we were human beings long before we were physicians. And, that we, too, experience loneliness, emptiness, depression and self-doubt. And, from time to time, we need to nourish and restore our own soul, remembering and honoring the commandment, 'Physician, heal thyself.'"

Richard J. Bagby, M.D.
President
Orange County Medical Society
Winter Park

Reprinted from *Central Florida Physician*, Vol. 2, No. 15, pg. 7, Orange County Medical Society, Orlando.

La vida no vale nada

While I enjoy the company of my colleagues, I have begun to dread the inevitable gloomy discussion of lost glory which ensues whenever two or more physicians gather for more than five minutes. A psychiatrist friend commented recently; "It's like Vietnam veterans, airing all their frustrations."

I think that we have somehow missed the big picture. Last week I had the pleasure of eating lunch with a group of nurses and technicians, and I was

struck by the difference in attitude which I encountered. Here were happy people! They discussed their plans for personal advancement, their vacations, the positive events in their lives. There was no bitterness or self-pity in evidence. Such a refreshing contrast to my usual lunches with physicians!

These good people would find it hard to fathom the unhappiness and negativism of you and me, when we enjoy security and financial rewards far in excess of theirs. I hope you will forgive me for mentioning this, but with the "big bucks" gone, we are still earning well over twice the average working man's wage, and enjoy unusual flexibility in both employment opportunities and working hours. Of course we endure a great deal of "stress," but the responsibility which produces this also allows us to take great personal satisfaction in our work.

Have we not harped on the negative aspects of medicine far too long? How about volunteering a comment about what nice people we are privileged to serve and how much we enjoy our relationships with them? How about acknowledging the satisfaction we feel when their life improves as a result of our efforts? Would it not be great to collar your pals with a thrilling account of the difficulties you skillfully surmounted during the diagnosis of that "interesting case" last week?

It would be one hell of a lot better than griping about how much you "hate this business."

Bill E. Barry, M.D.
Tampa

Reprinted with permission from *HCMA Bulletin*, September 1986, Vol. 32, No. 4, pg. 4

ESCAPE to STEAMBOAT

For a MEDICAL/DENTAL Seminar

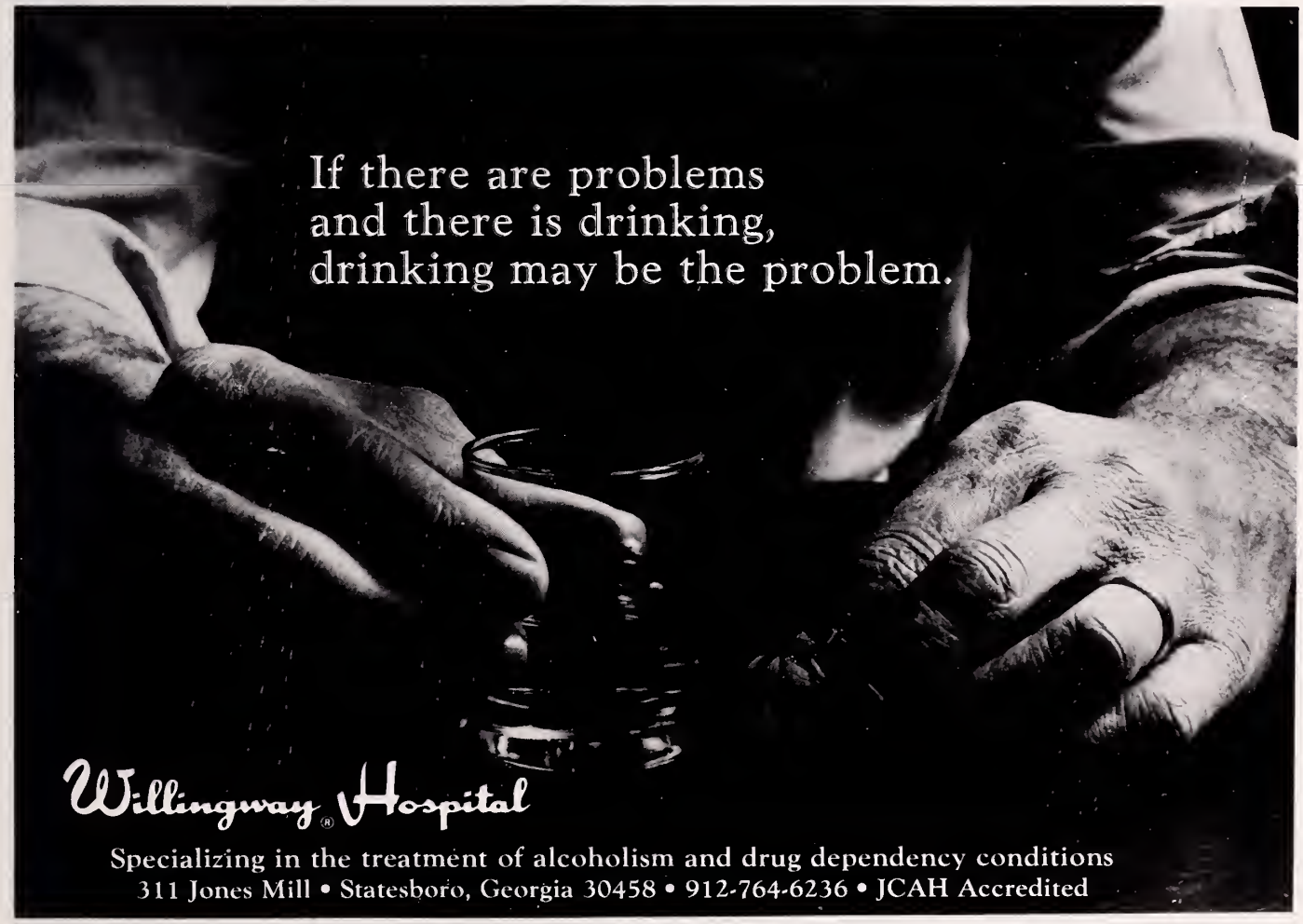
Meetings* are scheduled weekly in Steamboat Springs, from December 20th through April 17th and are approved for AMA, Category I.

For information call: 800-525-3402

or write to:
ASSOCIATION FOR CONTINUING EDUCATION
P.O. Box 774168
Steamboat Springs, Colorado 80477

ACE

*Programming meets IRS requirements for deductibility if the primory reoson for ottending is educational/professional.



Willingway® Hospital

Specializing in the treatment of alcoholism and drug dependency conditions
311 Jones Mill • Statesboro, Georgia 30458 • 912-764-6236 • JCAH Accredited

Learn about legal issues affecting medical staffs



The AMA Hospital Medical Staff Section Eighth Assembly

December 4-8, 1986 • Las Vegas Hilton

Special Educational Sessions:

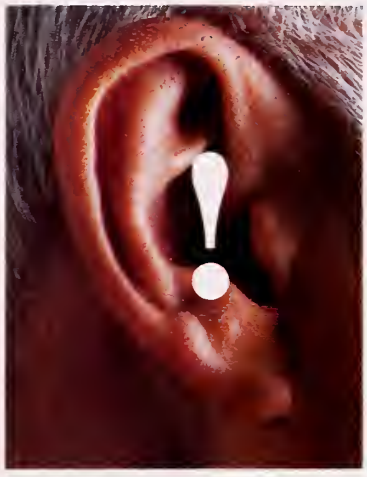
- Role of Medical Staff Legal Counsel
- Medical Staff and PRO Sanctions
- Antitrust and Credentialing
- Medical Staff / Hospital Board Relationships: Their Corporate Responsibility

Represent your medical staff.

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
Phone (312) 645-4747 or 645-4753

Every day more and more physicians are hearing something remarkable from some of their hypertensive patients...




SILENCE...

from the ones on once-daily

INDERAL® LA
(PROPRANOLOL HCl)

with a side-effect profile unsurpassed by atenolol or metoprolol.

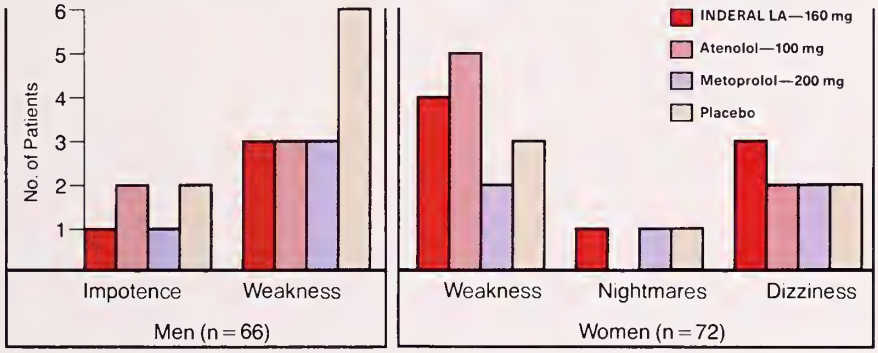
As seen in this double-blind, crossover, placebo-controlled study.[1]

Which shows you how truly well tolerated once-daily INDERAL LA can be.

What comes as *no* surprise, of course, is that it gives you the antihypertensive effectiveness you've come to expect from INDERAL.

Selected Side Effects

INDERAL LA as well tolerated as atenolol and metoprolol in a double-blind, crossover, placebo-controlled study of 138 hypertensives[1]



INDERAL® LA. For control.
Comfortable control. Once a day.
It's the last word.

Hypertensives: Feeling well and doing well, all in one.

INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

or

INDERIDE® LA
(PROPRANOLOL HCl [INDERAL® LA]/ HYDROCHLOROTHIAZIDE) LONG ACTING CAPSULES

As with all fixed-combination antihypertensives, INDERIDE LA is not indicated for the initial treatment of hypertension.

INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

Please turn page for brief summary of prescribing information.

Feeling well and doing well, all in one

ONCE-DAILY LONG ACTING CAPSULES 80 mg 120 mg 160 mg

INDERAL® LA
(PROPRANOLOL HCl)



*

ONCE-DAILY LONG ACTING CAPSULES 80/50 120/50 160/50

INDERIDE® LA
Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg



*

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*

INDERAL® LA Brand of PROPRANOLOL HYDROCHLORIDE **(Long Acting Capsules)**
INDERIDE® LA Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE **(Long Acting Capsules)**
INDERAL LA and INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY: Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS: Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence; and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias, headache; xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

* The appearance of these capsules is a registered trademark of Ayerst Laboratories

REFERENCE:

1. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321–1323.

6213/686

Ayerst® AYERST LABORATORIES
New York, NY 10017

Copyright © 1986 Ayerst Laboratories

The complete guide to women's health

by Bruce D. Shephard, M.D., F.A.C.O.G., and Carroll A. Shephard, R.N., RH.D. Price $11.95. Plume. 419 pages.

This book represents the most comprehensive detailed and readable book ever published for the educated woman in the United States. This book contains 11 sections, 87 chapters, 105 tables and 105 photographs. The authors have developed an extensive cross-reference indexing that allows the reader to select out any topic or area of interest. It also gives detailed resources of information including resource groups, as well as a careful glossary explaining the meaning of terms, and an index of further reading. The information reported is statistically detailed and documented by references at the end of each section.

The book covers topics ranging from "Choosing the Right Doctor" to "Physical Fitness;" "Natural Family Planning" to "Complications of Labor and Delivery;" "Pregnancy after 35" to "Drugs in Pregnancy;" "Toxic Shock Syndrome" to "Termination of Pregnancies;" "Nervousness and Anxiety" to "Vaginal Discharge;" "High Blood Pressure" to "Pelvic Pain;" "Acne" to "Breast Self-Examination." The authors clearly demonstrate extensive knowledge and experience in delivery of health care to the female population. They also clearly understand the needs and desires of women to know their own body and understand its function.

I would strongly urge that all providers of female health care read this book and use it in their reference library. Although most obstetricians and gynecologists would be fairly familiar with the material presented in this book, they may not have the statistical detail at their fingertips. Most family physicians and general internists who deal with many of the problems presented in this text would not be familiar with this material. It would, therefore, behoove all physicians attempting to deal with female health care and female health problems to read and be knowledgeable of the detail in this book.

I would like to take this opportunity to express my sincere congratulations to the authors as they have brought forth an outstanding reference book for our patients. I would encourage them to continue to revise this book every 3-5 years since we are dealing with such a rapidly changing field of health care.

Vincent G. Stenger, M.D., F.A.C.O.G.
Anne T. Stenger, B.S., M.S.
Sarasota

● Dr. Stenger is in private practice of Obstetrics and Gynecology in Sarasota, and is Clinical Professor of Obstetrics and Gynecology at the University of South Florida and former Professor and Chairman of the Department of Obstetrics and Gynecology at Pennsylvania State University. Ms. Stenger is a former teacher at the elementary, high school and college levels in the field of English literature and comprehensive writing, and has been a long-standing critic of female health care.

Feeling well and doing well, all in one.

ONCE-DAILY LONG ACTING CAPSULES 80 mg 120 mg 160 mg

INDERAL® LA
(PROPRANOLOL HCl)



ONCE-DAILY LONG ACTING CAPSULES 80/50 120/50 160/50

INDERIDE® LA

Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*

INDERAL® LA Brand of PROPRANOLOL HYDROCHLORIDE **(Long Acting Capsules)**
INDERIDE® LA Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE **(Long Acting Capsules)**
INDERAL LA and INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure; intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes; dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal. Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System. Dizziness, vertigo, paresthesias, headache; xanthopsia.

Hematologic. Leukopenia, agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular. Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity. Purpura, photosensitivity, rash; urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis); fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other. Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

* The appearance of these capsules is a registered trademark of Ayerst Laboratories

REFERENCE:

1. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321–1323.

6213/686

Ayerst® AYERST LABORATORIES
New York, NY 10017

Copyright © 1986 Ayerst Laboratories

Book Review Editor — F. Norman Vickers, M.D.

The complete guide to women's health

by Bruce D. Shephard, M.D., F.A.C.O.G., and Carroll A. Shephard, R.N., RH.D. Price $11.95. Plume. 419 pages.

This book represents the most comprehensive detailed and readable book ever published for the educated woman in the United States. This book contains 11 sections, 87 chapters, 105 tables and 105 photographs. The authors have developed an extensive cross-reference indexing that allows the reader to select out any topic or area of interest. It also gives detailed resources of information including resource groups, as well as a careful glossary explaining the meaning of terms, and an index of further reading. The information reported is statistically detailed and documented by references at the end of each section.

The book covers topics ranging from "Choosing the Right Doctor" to "Physical Fitness;" "Natural Family Planning" to "Complications of Labor and Delivery;" "Pregnancy after 35" to "Drugs in Pregnancy;" "Toxic Shock Syndrome" to "Termination of Pregnancies;" "Nervousness and Anxiety" to "Vaginal Discharge;" "High Blood Pressure" to "Pelvic Pain;" "Acne" to "Breast Self-Examination." The authors clearly demonstrate extensive knowledge and experience in delivery of health care to the female population. They also clearly understand the needs and desires of women to know their own body and understand its function.

I would strongly urge that all providers of female health care read this book and use it in their reference library. Although most obstetricians and gynecologists would be fairly familiar with the material presented in this book, they may not have the statistical detail at their fingertips. Most family physicians and general internists who deal with many of the problems presented in this text would not be familiar with this material. It would, therefore, behoove all physicians attempting to deal with female health care and female health problems to read and be knowledgeable of the detail in this book.

I would like to take this opportunity to express my sincere congratulations to the authors as they have brought forth an outstanding reference book for our patients. I would encourage them to continue to revise this book every 3-5 years since we are dealing with such a rapidly changing field of health care.

Vincent G. Stenger, M.D., F.A.C.O.G.
Anne T. Stenger, B.S., M.S.
Sarasota

● Dr. Stenger is in private practice of Obstetrics and Gynecology in Sarasota, and is Clinical Professor of Obstetrics and Gynecology at the University of South Florida and former Professor and Chairman of the Department of Obstetrics and Gynecology at Pennsylvania State University. Ms. Stenger is a former teacher at the elementary, high school and college levels in the field of English literature and comprehensive writing, and has been a long-standing critic of female health care.



It Shouldn't Even Be a Contest

You want what's best for your patients—not what's cheapest. Medicine shouldn't be practiced any other way.

Yet today's physicians are wrestling with a troublesome array of cost-containment initiatives: fee freezes, arbitrary caps on Medicare reimbursement, even restrictions on access to care. The stakes are high—life or death.

The AMA is in favor of cost-effectiveness, but not at the expense of quality care—or physicians' freedom to provide it. So we're acting, not reacting—by delivering cost-effectiveness information at special workshops and annual meetings; by offering publications including the Physician's Cost Containment Checklist; and by launching programs, such as the Cost-Effectiveness Network for hospital staffs to test cost-effectiveness strategies, and the Health Policy Agenda for the American People, a long-range set of directions and priorities for health care.

In Washington, D.C., and in court, we're fighting government-imposed fee freezes and other attempts to restrict the rights of physicians and patients.

You can fight back—by joining the AMA. Together, we'll help make sure that quality wins—every time.

For information, call toll-free 800/621-8335 (in Illinois, call collect 312/645-4987), or return this coupon to:

The American Medical Association

Division of Membership
535 North Dearborn, Chicago, Illinois 60610

Please send me AMA membership information.
☐ I am a member of my county medical society.

Name _____

Street _____

City _____ State _____ Zip _____

County _____

14-058

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HQ 10 AF/RSH
Bergstrom AFB, TX 78743-6002

Name _____

Address _____

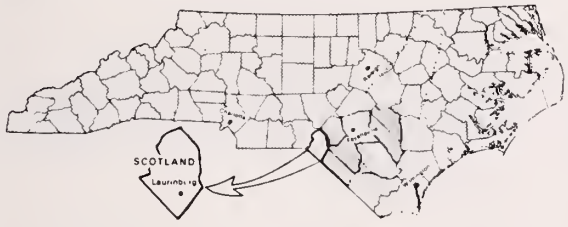
City _____ State _____ Zip _____

Phone _____ Prior Service? Yes ___ No ___

Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE



North Carolina

A strong medical community is seeking American Board Certified physicians to practice in a new 125-bed (all private rooms) not-for-profit hospital, state of the art equipped, located in a college community with over 25 major industries.

SPECIALTIES

Orthopaedics	Internal Medicine
Ophthalmology	(Gastroenterology)
Otolaryngology	(Pulmonology)
Obstetrics/Gynecology	Urology

Family Medicine

Please send CV in confidence to:
Physician Recruitment Committee
Scotland Memorial Hospital
500 Lauchwood Drive
Laurinburg, N.C. 28352
Attn: W.H. Davidson, M.D.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release



LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	300 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release



LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	250 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.



Each blue tablet contains:

Nicotinic Acid	100 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

YOUR NEW LOW DAILY RATES AT AVIS START AT $33.00



Avis features GM cars. Buick Century.

Your association membership means new, uniform low flat rates at Avis. And there's no charge for mileage. Choose from subcompact through full size 4-door car groups:

DAILY RATE	
SUBCOMPACT (Chevrolet Chevette or similar)	$33.00
FULL SIZE 2-DOOR (Buick Century or similar)	$39.00

These uniform low flat rates make it easy to know your rate before you go. To reserve a car, call Avis toll free: ***1-800-331-1212***

Be sure to mention your Avis Worldwide Discount number: **A/A616900.**

AVIS® ***WE TRY HARDER.®***

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. Flat rates are nondiscountable and are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. An additional charge per day will apply in certain locations including Newark Airport, NJ; LaGuardia Airport, NY; Kennedy Airport, NY; and all Manhattan locations. Check with Avis for the amount. Rates, discounts and additional charges subject to change without notice. Cars must be returned to rental location or higher daily rate and a one-way service fee will apply. Cars and particular car groups subject to availability. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

© 1985 Avis Rent A Car System, Inc., Avis®

Auxiliary Liason Editor — Mrs. Walter (Isabella) Laude

The FMA Auxiliary is a total way of life

The Auxiliary is a total way of life to me. What greater organization is there to work for than one whose goals support devoted and committed physicians who care about the quality of health and life for all people!

There is a health project for every aspect of life: Aging, Preventive Medicine Seminars for the Public, and Children and Youth. This year every county Auxiliary is being asked to research their needs, and then to work on the health project that benefits the people of their county.

The money raised for AMA-ERF is an investment for the future of the medical schools in our country. By helping students and research, it also becomes an investment in the quality of medicine.

International health funds go to underprivileged countries for children to receive surgery for the correction of defects resulting from birth anomalies, accidents, and burns. At the State Convention tears of joy have come to my eyes as I saw the happy faces of smiling children whose defects have been corrected enabling them to go out in the world, and to live normal lives.

The Florida Medical Foundation receives money that we raise to use for funds for medical education within our states and to provide for disaster relief for needy physicians and their families when necessary.

One of our key committees this year will be legislation. We are faced with critical health and medical issues. Once again, the bill that was passed in the Legislature for relief on professional liability is being challenged as unconstitutional.

With the medical societies and auxiliaries working together, we will have an impact on legislation. We will fight as never before to preserve the finest health care system in the world!

Membership is the life of our organization. I am proud to say we are second in the nation on our membership. We have the potential to be number one and this year we are going to work very hard on this. We will conduct a statewide Phon-A-Thon to all potential members who have not yet joined us. We need everyone.

My reward for all the years of working with this wonderful organization are the true friends I have made. They are lasting friends who cannot be bought or forgotten. They are my cornerstone that gives me the power of positive energy and drive to work for better goals, to do away with injustice, to right the wrong we see, and to help leave the world a better place than we found it. I am proud and privileged to be a member of this great organization which is a total way of life to me. I pledge my "Love and Commitment" to work hard for all our goals and to make 1986-87 a most successful year!

Mrs. V.A. (Susan) Marks
President
North Palm Beach

FLORIDA MEDICAL FOUNDATION
Needs Your HELP!

Please help by buying and encouraging others to buy:

Healthy Florida Citrus

The citrus is available throughout the year and can be mailed directly to your family and friends. Order now for Christmas. These are 25% tax deductible to the donor.

REMEMBER, of all the worthy Auxiliary projects, supporting FMF is the one thing we do for our "own." One of the most important uses of the profits is to support the Impaired Physicians Program.

Please continue to order citrus throughout the year. If you need brochures or order forms, contact your local auxiliary or:

Mrs. George R. Wilson (Priscilla)
2690 SR 13
Switzerland, FL 32043
(904) 268-8665

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as relafed to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsiblity: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

This space contributed as a public service.

YOU CAN FIGHT CANCER BEFORE YOU GET IT.

OR AFTER YOU GET IT.

It's a lot easier to fight cancer before you get it.

Scientists estimate that up to 60% of all cancer could be prevented.

By simply making a few changes in your lifestyle.

By not getting too much sun. By not smoking cigarettes. By not overeating. And by following a diet high in fiber and low in fat.

By simply doing these few things, you could drastically reduce your risk of getting cancer.

Sure, you could still get cancer.

But why not give yourself the odds against it?



Help us keep winning.

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

NOVEMBER

27th Workshop in Electrocardiography, Nov. 1-4, Sheraton Sand Key Resort, Clearwater Beach. For more info: Henry Marriott, M.D., 601 12th St. N., St. Petersburg, 33705, (813) 894-0790.

Internal Medicine Update, Nov. 3-7, Colony Beach & Tennis Resort, Sarasota. Contact: Murray Grossman, M.D., 750 East Adams Street, Syracuse, NY 13210, 473-4606.

Current Issues and Controversies in OB/GYN, Nov. 6-9, Hilton Hotel, Lake Buena Vista. Contact: John T. Hanigan, M.D., (201) 456-4267.

Neonatal and Pediatric Respiratory Disease Conference, November 6-9, Holiday Inn Sufside, Clearwater Beach. Contact: R.L. Siegel, M.D., USF College of Medicine, 12901, N. 30th Street, Tampa 33612, (813) 972-3131.

Calcium Antagonists and the Kidney, Nov. 7-8, LaCosta Carlsbad, California. Contact: Murray Epstein, M.D., Univ. of Miami, Dept. of Nephrology, P.O. Box 016960, Miami, FL 33101, (305) 324-3103.

Approach to Risk Management and Malpractice, Nov. 7-8, Sheraton Bal Harbour, Bal Harbor. For more information: Gloria Allington, Division of CME, University of Miami, P.O. Box 016960, Miami, (305) 547-6716.

American Heart Association ACLS Instruction Course, Nov. 8-9, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Lasers for the Plastic Surgeon, Nov. 14-16, Orlando Regional Medical Center, Orlando. Contact: Registrar, (312) 856-1818.

Current Advances in Perinatology, Nov. 16-22, Frenchman's Reef Hotel, St. Thomas, Virgin Islands. Contact: Charles Bauer, M.D., Dept. of Pediatrics (R-131), P.O. Box 016960, Miami, 33101, (305) 547-5808.

Fourth Annual Arnold Palmer's Children's Conference, Nov. 19-22, Buena Vista Palace Hotel, Lake Buena Vista. Contact: Patricia Martinez, Dept. of Pediatrics, ORMC, 1414 South Kuhl Avenue, Orlando, 32806, (305) 841-5143.

Flexible Fiberoptic Sigmoidoscopy, Nov. 20-23, Wyndham Hotel, Orlando. For more information: Edward J. Kowalewski, M.D., 132 East 70th Street, New York, N.Y. 10021, (212) 517-7520.

Tenth Annual Seminar of the Fla. Assn. of Pediatric Tumor Programs, Nov. 20-22, Hyatt Hotel, Orlando. Contact: Cindi Butson, P.O. Box 13372, University Station, Gainesville, 32604, (904) 375-6848.

Nutrition in Pediatric Practice — 1986, Nov. 21, Bay Harbor Inn, Tampa. For more info: Herbert Pomerance, M.D., 12901 N. 30th St., Box 15CE, Tampa, 33612-4799, (813) 974-4214.

DECEMBER

Magnetic Resonance Imaging, Dec. 1-5, 1986, Dec. 8-12, 1986, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Refinements in Gastroenterologic Diagnosis, December 3-5, 1986, Contemporary Hotel, Lake Buena Vista. Contact: H. Worth Boyce Jr., M.D., USF Medical Center, Box 19, 12901 N. 30th Street, Tampa 33612, (813) 974-2034.

Innovative and Controversial Strategies in Rehabilitation, Dec. 3-7, Sheraton Bal Harbour, Miami Beach. Contact: University of Miami, Dept. of Ortho/Rehab, P.O. Box 016960, Miami 33101, (305) 547-6716.

First Annual Oncology Conference, Dec. 4-5, Grand Cypress Hotel, Orlando. Contact: Florida Hosp. Cancer Center, 500 E. Rolling Street, #305, Orlando 32803, (305) 897-7600.

Workshop on Clinical Hypnosis, December 4-7, 1986, Tampa Hilton, Tampa. Contact: Alexander A. Levitan, M.D., 2051 Long Lake Road, New Brighton, Minnesota 55112, (612) 786-1620.

Treating Cocaine Dependency, Dec. 5, Stetson University, Deland. Contact: Peggy E. Stinson, M.D., (904) 734-4121 Ext. 488.

Vascular and Pulmonary Diseases, December 5-6, 1986, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson, 5808 S. Rapp Street, #202, Littleton, CO 80120, (303) 798-9682.

Magnetic Resonance Imaging, December 8-12, 1986, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Emergencies in Internal Medicine, Dec. 9-15, Virgin Islands. For more info: University of Miami, Dept. of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.

International Conference on Hypertension in the Elderly, December 12-16, Wyndham Hotel Sea World, Orlando. Contact: Bruce Robinson, M.D., (813) 974-2460.

JANUARY

Tenth Annual Oral Pathology Review, Jan. 10-14 and Jan. 31-Feb. 4, Miami. Contact: University of Miami, Division of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Nineteenth Seminar in Pediatric and Adult Urology, Jan. 21-24, Sheraton Bal Harbour, Miami Beach. Contact: Victor A. Politano, M.D., 6614 Miami Lakes Dr. East, Miami Lakes, 33014, (305) 687-1367.

Fourth Annual Doctors Hospital Winter Seminar, Jan. 24-31, Plaza Wood Creek, Mt. Crested Butte, Colorado. Contact: George T. Venis, M.D., 2295 Coral Way, Miami 33145, (305) 856-6121.

Oculoplastic Symposium 1987, January 24-31, University of Miami, Miami. For more information, contact: University of Miami, Department of Ophthalmology, P.O. Box 016960, Miami, 33101, (305) 964-0707.

Thirteenth Annual Vail Conference in Anesthesiology, Jan. 31-Feb. 7, Vail, Colorado. For more information: Sonja Craythorne, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101, (305) 547-6411.

FEBRUARY

Gastroenterology Update, Feb. 7, Mt. Sinai Medical Center, Miami Beach. Contact: University of Miami, Division of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Vail Symposium in Intensive Care, Feb. 7-14, Vail, Colorado. For more info: Sonja Craythorne, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6411.

Advances in Gene Technology, Feb. 9-13, Hyatt Regency, Miami. Contact: William J. Whelan, Dept. of Biochemistry, P.O. Box 016960, Miami 33101, (305) 547-6265.

Cardiopulmonary Rehabilitation Status '87, Feb. 10-14, University of Florida, Gainesville. Contact: Michael Pollock, Ph.D., Dept. of Medicine, Univ. of Florida, JHMHC J-277, Gainesville, 32610, (904) 392-0584.

Bascom Palmer Eye Institute 25th Anniversary Celebration, Feb. 19-21, Fontain Bleau Hotel, Miami Beach. For more information: Gaby Kressley, Dept. of Ophthalmology, P.O. Box 016960, Miami 33101, (305) 326-6031.

Third Annual Update on Neuro-Oncology, Feb. 24-25, Tradewinds Hotel, St. Petersburg Beach. For more info: S. Phuphanich, M.D., 12901 N. 30th St., Box 69, Tampa, 33612, (813) 974-3771.

Nineteenth Teaching Conference in Clinical Cardiology, Feb. 25-28, Sheraton Bal Harbour, Bal Harbour. Contact: Virginia McCars, Division of Research in Medical Education, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6491.

Selected Aspects of Internal Medicine, Feb. 28-March 6, Colorado, Telluride. Contact: University of Miami, Dept. of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

MARCH

Three-Day Diabetes Management Course, March 3-5, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Advances and Improvements in Hernia Surgery, March 12-14, Hyatt Regency, Miami. Contact: Arthur I. Gilbert, M.D., 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Cancer Conference Daytona Beach, March 13-14, Halifax Hospital Medical Center, Daytona Beach. For more information contact: Terry Bloom, M.D., (904) 254-4210.

Ninth Annual Family Practice Review, March 23-27, Holiday Inn Surside, Clearwater Beach. Contact: Charles Aucremann, M.D., 701 Sixth St. South, St. Petersburg 33701, (813) 983-6156.

APRIL

Pediatric Oriented ACLS Provider Course, April 3-5, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Issues in Prenatal Care — 1987, April 10-11, Indigo Lakes, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Blvd., Daytona Beach 32014, (904) 252-4701.

1987 Radiation Therapy Clinical Research Seminar, April 23-25, University Centre Hotel, Gainesville. Contact: Timothy A. Brant, M.D., Radiation Therapy Division, University of Florida, JHMHC J-385, Gainesville 32610, (904) 395-0287.

L'Humiditemp™

Protect and age your wines in the replicated environment of a subterranean French limestone cave . . . with L'Humiditemp, a product of today's technology.



Automatic humidity/temperature control. Free standing • 360 bottle capacity • Active odor filtration • Vibration free • Screens out light. Bottle aeration • Available with Many Options.

800-243-9355 • 617-593-3333
GIRONDE BROS., INC.
319 Lynnway, Lynn, MA 01901

Physicians' Confidential Assistance

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874 M D

THE FLORIDA MEDICAL FOUNDATION 1956

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

a division of Subscription Services, Inc.

29 Glen Cove Avenue • Glen Cove, New York 11542 • 516-676-4300

Our members qualify for low professional subscription rates for magazines for office reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION	(No. of issues per yr.)	REG SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE
American Health	10	14.95	12.95	11.95
American Heritage	6	24.00	18.00	18.00
Amer.Photog.[Special:	9 iss.]	7.47	7.47	
Americana	6	11.95	11.95	9.95
ArtNews	12	29.95	25.95	25.95
Atlantic Monthly	12	9.95	9.95	9.95
Audio	12	17.94	8.97	8.97
AUTOMOBILE MAGAZINE	12	24.00	12.00	
	2 yrs		22.00	
Basketball Digest	8	9.95	9.95	7.97
#Better Homes&Gdns	12	14.00	7.00	14.00
#BICYCLING	10	15.97	8.00	12.97
Black Enterprise	12	15.00	15.00	11.95
Boating	12	19.98	16.97	16.97
Bon Appetit	12	15.00	15.00	15.00
Boys Life	12	13.20	13.20	13.20
Car & Driver	12	16.98	11.99	11.99
child (Fashion)	6	12.00	10.00	10.00
Changing Times	12	15.00	9.97	9.97
#Connoisseur	12	19.95	10.00	19.95
Consumers Reports	12	16.00	16.00	16.00
#Cosmopolitan	12	24.97	15.00	24.97
Cruising World	12	18.00	18.00	14.00
Cycle	12	13.98	6.99	6.99
Cycle World	12	13.94	7.97	7.97
DISCOVER	12	23.95	13.00	14.95
Dog Fancy	12	17.97	17.97	12.97
Downbeat	12	18.00	18.00	9.95
EBONY	12	16.00	9.97	9.97
The Economist	52	85.00	51.00	51.00
#ELLE	12	24.00	16.00	
EM (Ebony Man)	12	24.00	19.95	19.95
ESQUIRE	12	17.94	9.95	9.95
Essence	12	12.00	9.96	9.00
Family Circle	17	14.97	9.97	
Family Computing	12	19.97	11.97	11.97
Family Handyman	10	9.95	9.95	5.95
Field & Stream	12	15.94	8.97	8.97
Fifty Plus	12	15.00	11.97	11.97
Financial World	26	41.95	24.94	
FLORIDA TREND	13	24.00	24.00	
Flying	12	18.98	15.97	15.97
Food and Wine	12	20.00	10.00	15.00
Football Digest	10	12.95	12.95	7.97
Forbes	28	42.00	42.00	28.00
Fortune	26	44.00	35.30	22.25
Games Magazine	12	15.97	15.97	15.97
Gentlemens Quartly	12	18.00	13.50	
Glamour	12	15.00	12.00	
Golf Digest	12	19.94	11.98	11.98
Golf Illus.[Special:	8 issues]	5.97	5.97	
Golf Magazine	12	15.94	9.97	9.97
#Good Housekeeping	12	15.97	9.97	15.97
Gourmet	12	18.00	13.50	15.00

PUBLICATION	(No of issues per yr.)	REG SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE
#Harpers Bazaar	12	16.97	8.97	16.97
Harpers Magazine	12	18.00	9.97	9.97
Health [Special:	9 issues]		9.97	9.97
High Fidelity	12	13.95	6.98	6.98
Home Mechanix	12	11.94	8.97	8.97
The Homeowner[Special:	6 iss]		8.97	8.97
Home Viewer	12	18.00	11.97	11.97
Hot Rod	12	13.94	8.97	8.97
House and Garden	12	24.00	18.00	
#House Beautiful	12	15.97	7.99	15.97
Inc.	12	24.00	12.00	12.00
Jet	52	36.00	26.00	26.00
Ladies Home Journl	12	19.95	11.97	9.98
LIFE	12	32.50	16.25	
M (Civilized Man)	12	24.00	19.95	
Mademoiselle	12	15.00	12.00	
McCall's	12	11.95	7.95	
Metropolitan Home	12	18.00	18.00	9.00
Modern Photography	12	13.98	7.98	6.99
MONEY	12	29.95	15.00	
Mother Jones	12	24.00	16.00	16.00
Motor Trend	12	13.94	7.97	7.97
MS Magazine	12	16.00	10.97	10.97
The Nation	52	28.00	28.00	
for Educators:		24 issues		9.95
Nation's Business	12	22.00	12.97	12.97
Natural History	12	20.00	20.00	
N.E.Journal of Med.	52		66.00	
New Republic	48	56.00	56.00	28.00
N.Y. Rev of Books	17	28.00	28.00	25.95
New Woman	12	15.00	9.95	11.97
New Yorker	52	32.00	32.00	20.00
#NEWSWEEK	52	41.00	20.80	21.85
OMNI	12	24.00	15.96	15.96
1001 Home Ideas[Spec'l:	8 iss]	11.97	11.97	
Organic Gardening	12	12.97	9.97	9.97
Outdoor Life	12	13.94	7.97	7.97
Outside	10	16.00	12.00	8.97
Ovation	12	18.00	10.00	10.00
PARENTING:	NEW!	STARTING Jan. 87		
Parents	10	18.00	9.00	
	12	18.00	9.00	
	2 yrs		18.00	
Penthouse	12	36.00	30.00	30.00
People	52	56.00	56.00	28.25
Personal Computing	12	18.00	18.00	11.97
Petersens Photgrph	12	13.94	6.97	6.97
Playboy	12	25.00	19.00	19.00
#Popular Mechanics	12	13.97	7.00	13.97
Popular Photogrphy	12	11.97	5.99	5.99
Popular Science	12	13.94	7.97	7.97
#PRACTICAL HOMEOWNER	9	10.97	5.50	9.97
#PREVENTION	12	13.97	7.00	13.97

PUBLICATION	(No of issues per yr)	REG SUBSCR PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE
PSYCHOLOGY TODAY	12	15.99	8.00	8.00
Radio-Electronics	12	15.97	12.97	12.97
Reader's Digest	12	15.41	15.41	15.41
#Redbook	12	11.97	6.97	11.97
Road and Track	12	17.94	12.99	12.99
Robb Report	12	65.00	65.00	
The Runner [Special:	8 iss.]		8.97	8.97
#RUNNER'S WORLD	12	19.95	10.00	12.97
Sail	12	21.75	21.75	21.75
Saturday Eve. Post	9	12.97	12.97	12.97
Savvy [Special:	9 issues]		8.97	8.97
Scientific Amer'n	12	24.00	24.00	24.00
Self	12	15.00	12.00	
Seventeen	12	13.95	13.95	13.95
Ski	8	11.94	6.97	6.97
Skiing	7	9.98	5.97	5.97
Skin Diver	12	13.94	7.97	7.97
SOUTHERN ACCENTS	12	18.00	16.00	
SPORT	12	12.00	7.97	7.97
Sporting News 24:6	mo	22.50	11.97	11.97
#Sports Afield	12	13.97	6.99	13.97
SPORTS ILLUSTRATED	54	58.80	34.00	29.45
Stereo Review	12	9.98	4.99	4.99
S.Porters Pers.Fin.	12	19.97	19.97	
TAXI (Fashion)	12	24.00	17.97	17.97
Teen	12	12.95	7.95	7.95
Tennis	12	17.94	8.97	8.97
TIME	52	58.25	29.25	
#Town & Country	12	24.00	12.00	24.00
Travel & Leisure	12	25.00	12.50	18.00
TV Guide	52	31.20	31.20	26.00
UNIQUE HOMES	6	29.97	24.97	19.97
USA Today	260	130.00	91.00	86.95
U.S.News&World Rep	52	34.50	34.50	17.25
US Magazine	26	23.95	12.98	12.98
	2 yrs.	23.95	23.95	
Vegetarian Times	12	19.95	14.95	14.95
Video	13	12.00	8.97	8.97
Video Review	12	12.00	6.97	6.97
Village Voice	52	32.76	32.76	16.50
Vogue	12	24.00	21.00	
W Magazine	26	26.00	23.00	17.95
Weight Watchers	12	13.97	11.97	11.97
Woman's Day	17	16.97	16.97	16.97
Women's Sports	12	12.95	7.97	8.95
WORKING MOTHER	12	11.95	7.95	
Working Woman	12	18.00	12.00	9.47
World Tennis[Special:	6 issues]	5.97	5.97	
WORLD TRAVELING	4	11.00	9.95	9.95
Writer's Digest [Spec:	9 iss.]	9.97	9.97	
Yachting	12	19.98	16.97	16.97
YM (Young Miss)	12	14.00	10.95	10.95

BUSINESS CARD NEEDED FOR OFFICE PRICE

FMA MAGAZINE PROGRAM
29 Glen Cove Avenue
Glen Cove, New York 11542

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Complete for Educator rates:

_____ Name of Educator

_____ Affiliated Hospital / School

☐ VISA
☐ M/C No. _____ Exp. Date _____

You may pay by check or credit card. Please make checks payable to FMA Magazine Program.

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

Terms: Subscriptions are one year unless otherwise noted. Prices subject to publishers' changes.
Guarentee: Our prices are the lowest, our service the best.
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.
New Orders: Publishers take from 8 to 12 weeks to start your subscription.

FLM01086

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

MEDSTAFF HAS PRACTICE OPPORTUNITIES in an array of Sun Belt locations. Options for locum tenens and/or permanent placements in all specialties. Work fulltime or parttime. Trial associations with established practices also available. Call Virginia Williams at (800) 833-3465 (U.S.) or (800) 672-5770 (NC) or write MEDSTAFF, INC., P.O. Box 15538, Durham, NC 27704.

OPENING FOR RADIOLOGIST: Diagnostic radiologist with interest and experience in mammography and ultrasound needed to staff new radiology office. Monday-Friday, 8-5. Florida License required. Salary negotiable. Contact K. Jay Adcook, M.D., 515 S. Orange Ave., Orlando, FL 32801, (305) 425-1518.

TALLAHASSEE, FL — Position available for Board Certified Family Practice or Emergency physician at Ambulatory Care Center owned and operated by local physicians. Opportunity available to begin private practice with minimal start-up costs if desired. Exceptional Florida community. Physician group is small, progressive, consumer oriented, offering unique opportunity for the right M.D. Please contact Douglas Sherman, M.D. or Bill Riddle at Physician Care, (904) 386-2266.

AGGRESSIVE, YOUNG, active and motivated F.P. looking for associate for office sharing leading to formation of group. C-1347, P.O. Box 2411, Jacksonville, 32203 or call (305) 842-5252.

DO YOU WANT TO SHARE a thriving dermatology practice? Do you enjoy year-round outdoor recreation? You should contact us. . .a progressive multispecialty group of 61 physicians in a pleasant, growing community. We offer a liberal financial package and outstanding benefits. Send curriculum vitae and references to: Michael T. Anderson, M.D., Willmar Medical Center, 101 Willmar Avenue SW, Willmar, MN 56201.

RADIOLOGIST — locum tenens wanted — North Florida practice with possibility of future association. Board qualified. Must have experience in all phases of Diagnostic Radiology including CT and angiography. Send CV with inquiry. C-1355, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST: Opportunity to join multispecialty group in a new and exciting concept of private medical practice in an attractive downtown Tampa office. Please send curriculumvitae to Richard Crane, M.D., 4215 North MacDill Avenue, Tampa, FL 33607, (813) 879-6380.

PEDIATRICIAN — multispecialty group in East Central Mississippi with three other pediatricians. Excellent fully equipped hospital, JCAH accredited. BC/BE. Initial salary with later productivity based income. Partnership in two years. No HMO/PPO affiliations. Send CV to Kenneth J. Reid Jr., M.D., Rush Medical Group, P.A., 1314 19th Avenue, Meridian, MS 39301.

FT. LAUDERDALE AREA — Physician wanted for walk-in family medical center. Excellent salary and incentives. Partnership available. Contact: Mrs. King, (305) 752-1343, or send CV to C-1356, P.O. Box 2411, Jacksonville, FL 32203.

NEUROLOGIST — Established headache clinic in Tampa expanding, needs BC/BE associate with Florida license to join Senior Neurologist. Excellent practice opportunity for young neurologist with keen interest in headache diagnosis and management. First year salary with incentives leading to partnership opportunity. Send CV and personal requirements to: A. Carvel Gipson, M.D., 2727 W. Buffalo Ave., Tampa, FL 33607.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

FT. PIERCE, FLORIDA — Full time emergency department position available in a 240 bed hospital with an annual ED volume of 24,000. Candidate must be board prepared in emergency medicine. The hospital is centrally located between Disney World and Miami on Florida's Treasure Coast. Excellent compensation and malpractice insurance provided. Please send CV to Cheree Richards, EMSA, 8200 W. Sunrise Blvd., Plantation, FL 33322, or call (305 472-6922.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

INTERNAL MEDICINE:Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

FAMILY PHYSICIAN: B.E. or B.C. for West Palm Beach practice. Florida license necessary. Opportunity for future partnership. 305-967-0234.

GENERAL INTERNISTS, FAMILY PRACTICE, GERONTOLOGIST, EMERGENCY CARE MEDICINE, PEDIATRIC SURGEON 40 physician multispecialty Group in West Palm Beach, Florida seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send C.V. to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 North Olive Avenue, West Palm Beach, Florida 33401.

INTERNIST — Internist, board certified/board eligible, wanted to join solo practice on Florida East Coast. Opportunity to step into a ready made practice with no investment and potential for full practice with in a year. Reply to Box C-1348, P. O. Box 2411, Jacksonville, FL 32203.

PSYCHIATRIST — full-time position open for Board Certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient and limited inpatient on-call. Florida license needed. Reply to Box C-1349, P. O. Box 2411, Jacksonville, FL 32203.

GYNECOLOGIST to take over small active practice in sunny Southwest Florida. Small investment — active group practice — referrals. V.C. Ratnesar, M.D., 707 Del Prado Blvd., Cape Coral, FL 33904.

MEDICAL COMPLEX in the lovely Gulf Coast community of Englewood, FL (Sarasota county) seeking well-qualified physicians (general and specialty) who would be affiliated with the Venice and Englewood Community Hospitals. Phone 813-474-7772 or 2011 Englewood Rd., Englewood, FL 33533, c/o Dr. Ryan.

INTERNIST WANTED: Experienced Board Certified Internist for established West Palm Beach Internal Medicine Practice. Send CV to C-1358, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST to work in new group practice in sunny Southwest Florida. Fully equipped office. No investment. V.C. Ratnesar, M.D., 707 Del Prado Blvd., Cape Coral, FL 33904.

ORLANDO AREA — Urgent Care Center has full and parttime positions for physicians with background in F.P., I.M., or E.M. immediately available. No nights. Urgent care experience preferred. Good personality and good communications skills essential. Excellent compensation and growth potential with expanding national health care corporation. Please send C.V. and professional references to: General Manager, Dept. C., P.O. Box 15156B, Orlando, FL 32858.

PUBLIC HEALTH — Health Program Officer — The Florida Department of Health and Rehabilitative Services seeks a highly qualified person to head a District public health program. This position is responsible for providing professional public healht and medical expertise to the administration of health services to seven County Health Departments. The position is titled District Health Program Supervisor — HRS and reports to the District Four Administrator. The successful candidate will be required to obtain a Florida medical or osteopathic license and must have progressive experience in public administration. An M.P.H. is desired. Salary negotiable. Reply to: James T. McGibony, M.D., District 4 Health Program, P.O. Box 2417, Jacksonville, FL 32231-0083. EEO/ Affirmative Action Employer.

Situations Wanted

VASCULAR — GENERAL SURGEON -BC- Vascular fellowship, presently in private practice. Desire multi-specialty group. Reply to Box 1340, P. O. 2411, Jacksonville, FL 32203.

VASCULAR GENERAL SURGEON, vascular surgery fellowship. Board certified, desire group practice situation in Southern Florida. Call 206-326-5891 or write S. Goff, 528 18th Ave., Seattle, WA 98122.

FAMILY PRACTITIONER, BC, Florida license looking for association, partnership or buying solo practice in Central Florida. Other areas considered. Reply, C-1198, P.O. Box 2411, Jacksonville, FL 32203.

GENERAL AND VASCULAR SURGERY with endoscopic experience. Now a chief resident in a university program. Available July, 1987. Desire solo, partnership, or group practice opportunity. C-1352, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE PHYSICIAN, New Jersey, Board Certified, Florida Licensed, with extensive experience in primary care, seeking employment opportunity in Southeast Florida. I am looking for office based work, full or parttime, no pediatrics. Available in Jan. or Feb. 1987. HMO's, group practices, or individual physicians having such opportunity can reach me: 201-334-1660 or evening 201-334-0363. Job must be within reasonable driving distance of Boca Raton where I will reside.

MEDICAL PRACTICE ADMINISTRATOR with over 15 years experience developing a general practice to 25,000 active pt. base seeks stable, long term situation dedicated to quality patient care and prudent business decision-making. Contact Dr. P. Callahan, Callahan & Associates, P.O. Box 1686, Largo, FL 34294, (813) 584-4275.

AUSTRALIAN FAMILY PRACTITIONER holding FL license and British MRCP in internal medicine wishes to join family practice in Orlando. Arriving in Orlando early January. Use local contact Mrs. J.D. Mahaffey, 747 Jamestown Drive, Winter Park, FL 32791.

Practices Available

RADIOLOGY OFFICE FOR SALE OR LEASE. Established 8-year old private office being offered due to illness of owner. Services supplied include fluoroscopy, ultrasound, tomography, xeromammography and digital imaging. Most equipment less than 4 years old, will consider employment of associate radiologist up to two years. 145 Orange Avenue, Rockledge, Fl 32955, (305) 632-2914.

UROLOGICAL PRACTICE for sale - Tampa Bay area. Urologist retiring. Available October 1986. Reply to Box C-1350, P.O. Box 2411 Jacksonville, FL 32203.

ESTABLISHED FAMILY—AVIATION MEDICINE PRACTICE, Miami, FL. Fully equipped office with assuable lease, fee-for-service, 24 hour week, good coverage and excellent growth potential. Gross in excess of $150,000. Easy terms, will introduce. Contact 36 Westward Dr., Miami Springs, FL 33166 or phone 305-888-1622.

TAMPA. ACTIVE FAMILY MEDICINE/GERIATRIC medical practice available with fully equipped office. North Tampa area. Physician retiring. Will negotiate terms and introduce. C-1354, P.O. Box 2411, Jacksonville, FL 32203.

ANTICIPATING RETIREMENT. IM, CVB practice over 30 years in community. Central West Coast Fl. Need to be BE, BC. Two hospitals within three miles of office. Will stay, introduce. Office, practice available. C-1346, P.O. Box 2411, Jacksonville, FL 32203.

PRACTICE FOR SALE: On busy corner thoroughfare. Sixteen years in practice. Family practice with general surgery. Office complete with lab facilities, including EKG, X-rays, spirometry, etc. Terms negotiable. Available immediately. Northeast Florida. C-1360, P.O. Box 2411, Jacksonville, FL 32203.

DERMATOLOGIST PRACTICE FOR SALE: Fully equipped beautifully furnished offices in prestigious doctors building ideally located. Assist in turnover. Great opportunity. Dr. J.J. Eller, 2601 N. Flagler Drive, West Palm Beach, FL 33407. (305) 832-4109.

PEDIATRICS: North Florida. Well-established practice. Will phase out. Equipment available. Building for rent or sale. Pay off over 10 years. C-1359, P.O. Box 2411, Jacksonville, FL 32203.

SUNCOAST FLORIDA — 20 yr. general practice. Location, facilities, practice, patient population all great. 1618 Dixie Highway, Holiday, FL 33590.

Real Estate

SPRING HILL, FL - 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease - owner will finance. (904) 596-4162 weekdays.

RETIRING BOARD CERTIFIED OB-GYN selling or leasing completely equipped office. Capacity for 2 or more Ob-Gyns. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone 305-667-3677.

CAYMAN ISLANDS — modern 2 bedroom beach house on Cayman Brac. Superb snorkelling and scuba. Quiet out-island setting. Rental $350.00 per week. Dr. R. Lament, 2187 West 4th Avenue, Vancouver B.C. Canada (604) 733-5722.

OFFICE FOR LEASE — 1500 sq. ft. of finished professional space in Gentry Building, U.S. Highway No. 1, North Palm Beach, FL. Prime location on ground floor. Suitable for any specialty. Available November. Phone 626-8300.

PRIME OFFICE SPACE FOR LEASE OR PURCHASE: 844 West Plymouth Ave., De Land, Fl. (1 block from West Volusia Hospital) Luxury @ 2000 Sq. Ft professional office, 2 bath, 1 pvt. bath/shower, 2 executive offices with pvt. interconnecting lounge/bath-shower, 4 exam rooms, common reception area with large waiting room, common business area. Lease: $2200.00 per Mo. Purchase: $185,000. Lease/Purchase available. Interested parties: (904) 736-6110.

FOR SALE: Home, office and family practice on lovely Plantation Key. Ideal situation for semi-retired physician with a spirit of adventure. $225,000. (305) 852-7993.

Services

WE BUY, SELL, LEASE SERVICE new and preowned medical instrumentation: Holter-Stress-Ultrasound-EKG Lab etc. Contact New Life Systems, Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065; 305-972-4600.

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

ATTORNEY FOR PHYSICIANS for business, professional regulation, records, malpractice, and standard of care issues. Vitae: Doctor of Science, Health Services Administration (University of Pittsburgh); Juris Doctor, Law (Creighton University); 20 years health-care experience; Professor; publications. Licensed to practice law in Florida, Michigan, and Nebraska. Contact: Robert Woody, Attorney at Law, Suite 205, 1950 Courtney, Fort Myers, FL 33901; telephone (813) 939-4321.

MEDICAL PRACTICE SALES AND APPRAISALS. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our Brokerage Division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004, 215-667-8630.

LONG TERM FINANCING for starting/purchasing practices, diagnostic centers, equipment, office condos, buildings. $25,000 to $1,000,000. Western Financial, 1380 Miami Gardens Drive, N. Miami Beach, FL 33179, (305) 949-5900.

Equipment

WORD PROCESSOR — SONY. Take over lease - no downpayment, series 35 partial page, dual disk drive, 55 CPS printer. 14 months on lease at $730 per quarter. Option to purchase/investment tax credit. C-1357, P.O. Box 2411, Jacksonville, FL 32203.

HOLTER MONITOR: Quality scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretation, scan price $35.00. Recorders loaned, leased or purchase new dual-channel holter recorder, $995.00 with one year warranty. For more information call collect, Advance Medical & Research Center, Inc., 1-313-373-1199.

FOR SALE: Medical Equipment and supplies, including QBC blood analyzer, A-O microscope, Burdick EK-100 EKG, defibrillator, hyfrecator, x-ray duplicator, view boxes, shelving, miscellaneous instruments, office and medical supplies. Package deal. Box C-1361, P.O. Box 2411, Jacksonville, FL 32203.

FOR SALE: JEDMED Axisonic II A Scan with rolling stand, used only 15 times. $3,500.00. (904) 824-1767 nights.

Meetings

1987 CME CRUISE/CONFERENCES on selected medical topics — Caribbean, Mexico, Hawaii, Alaska, China/Orient, Scandinavia/Russia. 7-14 days year round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) and AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican & Alaskan cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746 (516) 549-0869.

BIOFEEDBACK THERAPIST TRAINING WORKSHOP — Four day program to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. Medical CEUs pending. September 25-28 or November 13-16, 1986. Tentative 1987 dates: February 6-9, April 24-27, or June 12-15. For brochure contact: Hartje Stress Clinic, 2429 University Blvd. West, Jacksonville, FL 32217. (904) 737-5821.



ADD NEW PATIENTS

A Nutrition Medical Centers franchise can help your practice grow. A logical extension of your professional knowledge and facilities, our proven system of nutrition counseling can create a new profit center for your practice. For more information on this exciting opportunity call (404) 872-4900.

NUTRITION MEDICAL CENTERS

1750 Peachtree St. N.W.
Suite 305
Atlanta, Georgia 30309
(404) 872-4900

GET MORE FOR YOUR ADVERTISING DOLLAR

Purchase A Display Ad in the

Journal of the Florida Medical Association, Inc.

Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203

(904) 356-1571

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name: _____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

ADVERTISERS

Air Force
Recruitment . . . 743

Air Force Reserves
Recruitment . . . 805

American Medical Association
Health Insurance Claim Forms . . . 740

Army/Army Reserves
Recruitment . . . 757

Association for Continuing Education
Seminar . . . 801

AT&T
Service . . . 735

Ayerst Laboratories
Inderal LA/Inderide LA . . . 802a
Premarin . . . 734b

Brown Pharmaceutical
Android . . . 743
Lipo-Nicin . . . 805

BellSouth Mobility
Service . . . 752

Business Solutions Technology
Qwik Claim . . . 736

Curtis 1000 Information Systems
Computers . . . 786d

Eli Lilly & Company
Ceclor . . . 787

Fair Oaks Hospital
Service . . . 737

FMA Sponsored Insurance Plans
Service . . . 751

Florida Physicians' Insurance Company
Service . . . 734

Glaxol/Roche
Zantac . . . 782a

GTE Telenet
Service . . . 782

Gironde Bros., Inc.
L'Humiditemp . . . 811

Health Cap
Service . . . 758

Knoll Pharmaceutical Company
Vicodin . . . 786c

Marion Laboratories, Inc.
Cardizem . . . 750a

Nutrition Medical Centers
Service . . . 816

Roche Products, Inc.
Dalmane . . . 819

Scotland Memorial Hospital
Recruitment . . . 805

Smith, Kline and French Company
Dyazide . . . 734a

Upjohn Company
Motrin . . . 786a

Willingway Hospital
Service . . . 801

Florida Medical Association Officers and Council Chairmen

Officers

James B. Perry, M.D., Ft. Lauderdale, President
James G. White, M.D., Ormond Beach, President-Elect
Kay K. Hanley, M.D., Clearwater, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Charles P. Hayes Jr., M.D., Jacksonville, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
Thomas D. Bartley, M.D., Gainesville, Specialty Medicine
Thomas M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®

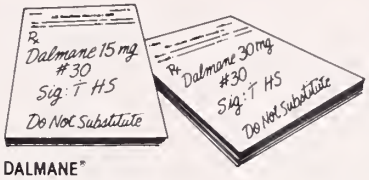
brand of
flurazepam HCl/Roche Ⓥ

sleep that satisfies

15-mg/30-mg
capsules



References: **1.** Koles J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Koles A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Koles A, *et al: Clin Pharmacol Ther 19*:576-583, Moy 1976. **4.** Koles A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Koles A, Koles JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennont FS, *et al:* Symposium on the Treotment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblott DJ, Allen MD, Shoder RI: *Clin Phormacol Ther 21*:355-361, Mor 1977.



DALMANE®
brand of
flurazepam HCl/Roche Ⓥ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see adjacent page for references and summary of product information.

DALMANE®

brand of
flurazepam HCl/Roche ⓒ

sleep that satisfies



C01183 OCO
COLL.OF PHYS.OF PHILADELPHIA
LIBRARY
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

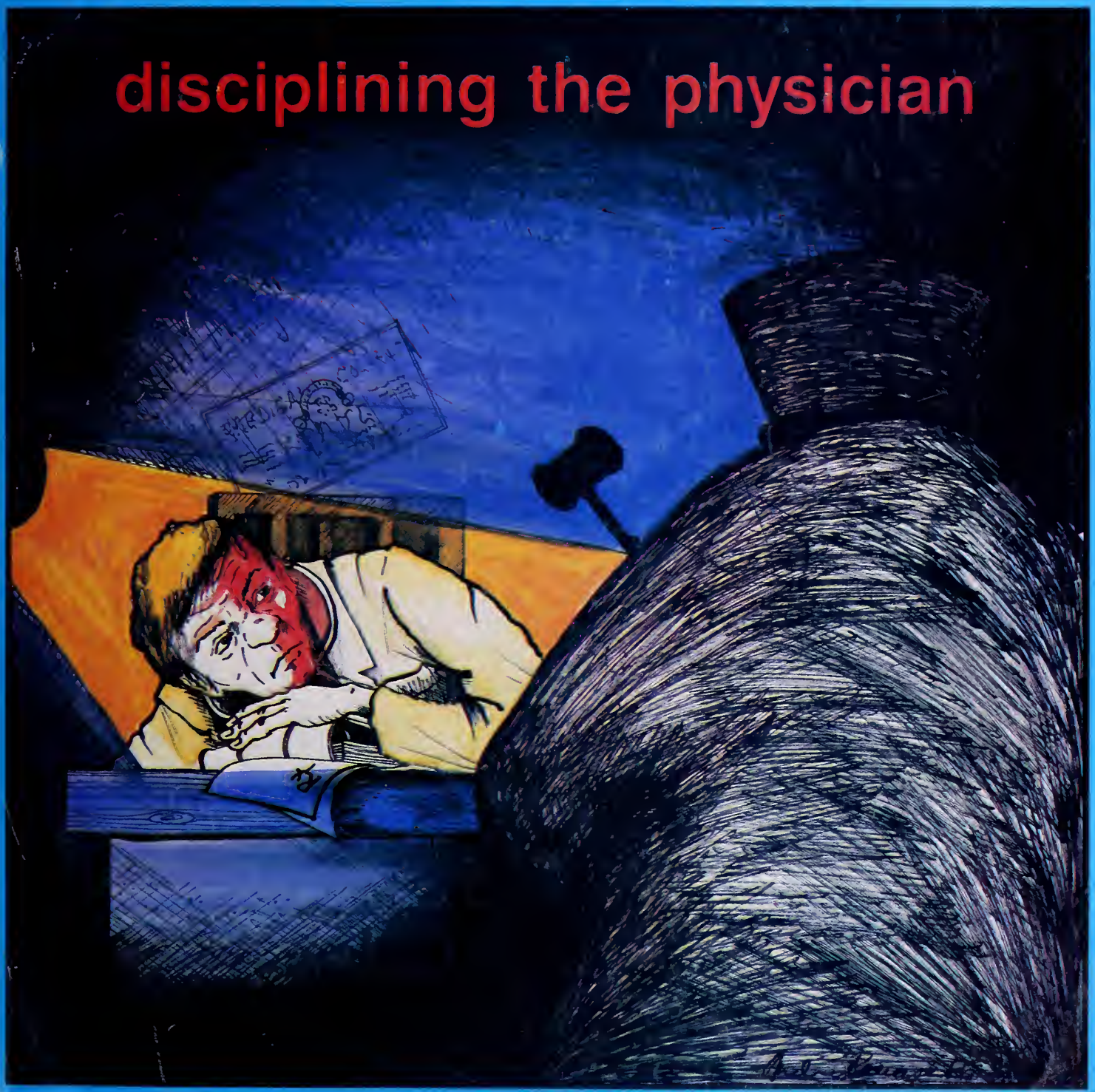
ROCHE®

Copyright © 1986 by Roche Products Inc. All rights reserved.

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. NOVEMBER 1986, Vol. 73, No. 11

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
DEC -1 1986
M. D.

disciplining the physician



Select Quality!

The chart on this page can be used to compare the advantages of insuring with Florida Physicians Insurance Company. All medical professional liability insurance coverage is NOT the same!

QUESTION	FPIC	PPTF	ST. PAUL
Are your carrier's premiums non-assessable ?	YES	NO	YES
Is your carrier medical association sponsored ?	YES	NO	NO
Is your carrier Florida owned and operated ?	YES	YES	NO
Is the majority of your carrier's Board of Directors made up of physician's ?	YES	YES	NO

For more information call Ron Gladman:

FPIC FLORIDA PHYSICIANS INSURANCE COMPANY

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

Every day more and more physicians are hearing something remarkable from some of their hypertensive patients...




SILENCE...

from the ones on once-daily

INDERAL® LA
(PROPRANOLOL HCl)

with a side-effect profile unsurpassed by atenolol or metoprolol.

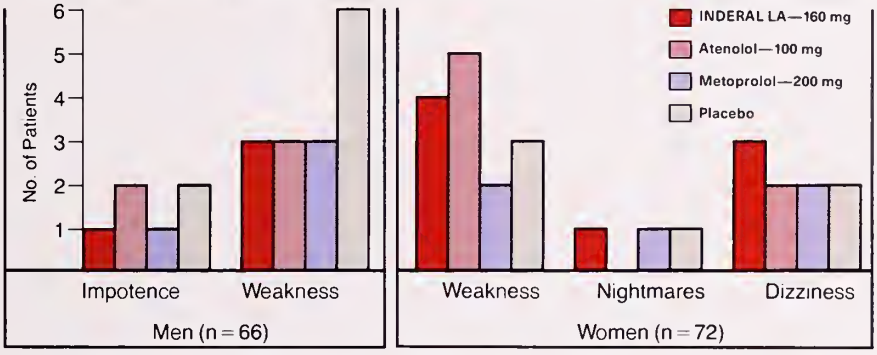
As seen in this double-blind, crossover, placebo-controlled study.[1]

Which shows you how truly well tolerated once-daily INDERAL LA can be.

What comes as *no* surprise, of course, is that it gives you the antihypertensive effectiveness you've come to expect from INDERAL.

Selected Side Effects

INDERAL LA as well tolerated as atenolol and metoprolol in a double-blind, crossover, placebo-controlled study of 138 hypertensives[1]



INDERAL® LA. For control.
Comfortable control. Once a day.
It's the last word.

Hypertensives: Feeling well and doing well, all in one.

INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

or

INDERIDE® LA
(PROPRANOLOL HCl [INDERAL® LA]/ HYDROCHLOROTHIAZIDE) LONG ACTING CAPSULES

As with all fixed-combination antihypertensives, INDERIDE LA is not indicated for the initial treatment of hypertension.

INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

Please turn page for brief summary of prescribing information.

Feeling well and doing well, all in one.

ONCE-DAILY LONG ACTING CAPSULES

INDERAL® LA
(PROPRANOLOL HCl)

80 mg 120 mg 160 mg *



ONCE-DAILY LONG ACTING CAPSULES

INDERIDE® LA
Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg

80/50 120/50 160/50 *



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*

INDERAL® LA Brand of PROPRANOLOL HYDROCHLORIDE **(Long Acting Capsules)**
INDERIDE® LA Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE **(Long Acting Capsules)**
INDERAL LA and INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely. If propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS: Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability; slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions; psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash; urticaria; necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

* The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCE:

1. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321–1323.

6213/686

Ayerst® AYERST LABORATORIES
New York, NY 10017

Copyright © 1986 Ayerst Laboratories



FAIR OAKS HOSPITAL
QUALITY PSYCHIATRIC CARE

Fair Oaks Hospital at Boca/Delray is a psychiatric facility that values the judgment of the referring physician. Our specialty programs are led by full-time Yale-trained psychiatrists who value and utilize the medical model.

As the referring physician, you have the opportunity to collaborate closely with our staff physicians during all phases of evaluation and treatment.

A thorough patient evaluation is conducted on the Neuropsychiatric Evaluation Unit before treatment is administered. Thorough medical, neurological and neuroendocrine testing is performed, in addition to psychological and family assessments. Individualized treatment plans are carried out by our multidisciplinary treatment teams on our Adult Psychiatric Unit, Addiction Unit and Adolescent Hospital.

The Addiction program specializes in cocaine abuse and has pioneered in new treatments for the cocaine abuser.



Fair Oaks also has a unique reference source . . . cocaine addicts themselves.



Serving as the local sponsor for the **1-800-COCAINE** National Helpline for Florida callers, we have a direct link to drug users. Fair Oaks is able to apply Helpline information in the development of treatment and research programs.

The Adolescent Hospital is under the direction of a full-time board certified child and adolescent psychiatrist and includes a full-time school program. Specialized tracks exist for adolescent patients with psychiatric and substance abuse problems. Admissions counselors are available 24 hours a day to discuss all details concerning the hospital.

For more information call or write:

Admissions Coordinator
Fair Oaks Hospital at Boca/Delray
5440 Linton Boulevard — 305/495-3737
Delray Beach, FL 33445 — 305/495-1000

FAIR OAKS
HOSPITAL
AT BOCA/DELRAY

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

NOVEMBER 1986, Vol. 73, No. 11

CONTENTS

SCIENTIFIC ARTICLES

J. Donald Temple, M.D., William J. Harrington, M.D., Yeon S. Ahn, M.D., and Evan Rosenfeld **847** Treatment of sickle cell disease with danazol

Michael J. Carmichael, M.D., Daniel R. Salomon, M.D., and L. Anne Sadler, R.N., B.S.N. **849** Cardiac transplantation: the first year's experience at the University of Florida-Shands Hospital

Ronald E. Domen, M.D. **855** The single-unit transfusion

SPECIAL ARTICLES

Richard J. Feinstein, M.D. **861** Barriers to effective medical discipline and some possible solutions

Pierre J. Bouis Jr., M.D., and Robert C. Fore, Ed.D. **866** New rules link CME to licensure renewal

COVER

This month's cover of *The Journal* is an illustration by Andre Renard, M.D., Jacksonville, depicting the Special Article on disciplining the physician.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.* [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc., are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Florida Medical Association, Inc.

DEPARTMENTS

827 President's Page
Sovereign immunity
James B. Perry, M.D.

831 Editorials
Freedom to practice slipping away
R. G. Lacsamana, M.D.
Thoughts on Thanksgiving
Clyde M. Collins, M.D.
Ethics in medicine
Edward Pedrero, M.D., Ph.D.

839 Letters & Viewpoints

871 Medical Economics
Physicians and the challenge of politics
Jacques R. Caldwell, M.D.

879 Notes & News

880 Dean's Message

881 Encores!

885 Book Review

887 FMA Auxiliary
Windflowers of the tropics aid AMA-ERF
Mrs. Randall (Sue) Bertolette

890 Meetings

894 Classified Advertising

898 Index to Advertisers

898 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Pierre J. Bouis Jr., M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Karl Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.

ALWAYS ON CALL:

AT&T'S NEW DOCTOR'S SOLUTION ASSISTS YOU ROUND-THE-CLOCK WITH EVERYTHING FROM ACCOUNTS RECEIVABLE TO SCHEDULING.

Few doctors like to think of their practice as a business, but of course it is.

So the less you have to think about business, the more you can concentrate on medicine.

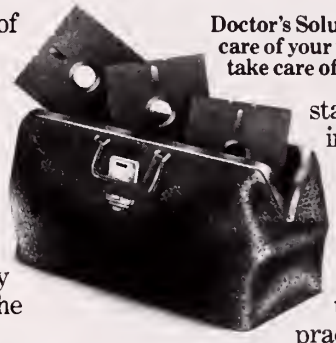
That's why AT&T tailored a complete hardware and software package specifically for the medical profession. The Doctor's Solution.

It's just one member of a whole family of Health Care Information Systems. AT&T Doctor's Solution provides total office management for single and multi-doctor practices.

Far from forcing you to change the way you run your practice, Doctor's Solution simply allows you to run it more efficiently with help like this:

Automated billing gathers all charges to each patient—including exams, tests and prescriptions—and automatically calculates a single, comprehensive bill.

Accounts receivable tracks all receivables, selects balance-forward or open-item statements, sets aging intervals, and spots delinquent accounts. All of which improve your collection rates.



Doctor's Solution software takes care of your paper work so you can take care of your patients.

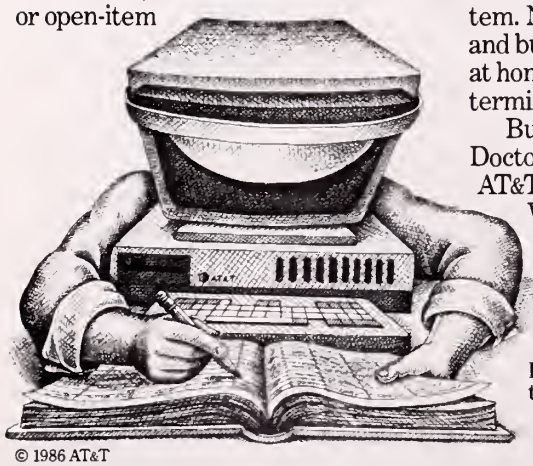
Practice management improves the flow of your practice with the ongoing maintenance of complete patient histories. Both clinical and billing information follow every patient through your office.

Patient scheduling by practice, doctor, week or month—including rounds and vacations—helps you get the most out of your time so you can give the most to your patients.

Third-party billing increases your cash flow by accommodating unlimited fee schedules and generating a variety of forms and invoices.

Remote access to your office system. Now you can get complete clinical and business information at the hospital, at home—anywhere there's a phone, a terminal or PC, and a modem.

But one of the nicest features about Doctor's Solution is that it's backed by AT&T's Small Business Connection. Which means our specialists in the medical field will make sure you get the right hardware, the right software and the right training.



By tracking who owes what, the system helps pay for itself.

As your practice grows, these specialists will help you keep your system right in step—accepting new doctors, new procedures and new diagnostics.

What's more, Doctor's Solution will work with every **UNIX™** System-based computer AT&T makes. Just one more example of "The Computers With The Future Built In."

And if you have a problem? We not only have a Service Hotline; we even do over-the-phone software diagnostics.

It's all part of AT&T's unique approach to small business. You don't just buy a system. You buy AT&T's end-to-end responsibility for that system.

And you buy it from a single source with a proven past. And a very healthy future.



Give us a call at 1 800 247-7000. We'll show you how to get your practice a lot closer to perfect.

AT&T
The right choice.

© 1986 AT&T

Sovereign immunity



In the delivery of health care to the indigent and aged who tend to be medically indigent at times, there is a feeling that responsibility for this ever-increasingly large proportion and volume of society is that of society itself. Directly and indirectly this is also, to an extent at least, the responsibility of those receiving the care.

Perhaps one could make the argument, or philosophical tenet, that all of us will someday be elderly, and perhaps indigent to an extent as far as the high-tech cost of quality care is concerned. Thereby, we could participate in a program of taxation, be it sales, ad valorem or income, toward a time when we are no longer able to participate because of decreased working years and relative earning abilities, then be able to recoup some of the good efforts of our younger years and expect those in their younger years to help support us. This would be outside the realm of Medicare- or Medicaid-type programs, but directly in a people-to-people sponsorship program.

Associated with this philosophy is an emotional feeling. Since the physician is the "at risk person" delivering the care, he and the caring institution, be it a state or county supported hospital or a private institution, even a nonprofit private institution, should be immune from litigation to an extent possible. Those who have been wronged through negligence should be able to recoup their rightful economic and medical costs, as well as an automatic additional fee for their injury, without having to settle for 28 cents on the premium dollar or going through a lengthy court trial with all its demeaning facets. Resolution of the problem should occur on an "administrative" basis with rapid, fair, just, and equitable treatment of all parties concerned. This is sometimes referred to as "sovereign immunity."

One of the philosophical parameters of such a plan is that in a "doctrine of fault" where fault is obvious in a negligent action and not a difficult problem for adjudication or, for that matter, in an obviously spurious claim, the solution and administrative details are not serious problems, although they may be somewhat complex.

It would seem that the greatest difficulty arises in the large group that falls into a gray area. In this situation, the division is 40 to 60, either way without clear-cut answers. The problem for organizations administratively in this type scenario is: would the doctrine of sovereign immunity be invokable?

The question then arises: will the plaintiff's rights be abrogated by dismissal of complaint after investigation? The patient may be so afflicted as to preclude working again and have significant medical bills which he is unable to pay. On the other hand, such a patient, even though there is no apparent fault on the part of the physician who has a bad result, is unable to pay for additional needed care. Should he be entitled to compensation for all economic damages and the additional settlement of the relative value of the disabled and or afflicted body part?

The moral and ethical issues are tremendous and could conceivably open up a whole new area of law on challenges at an administrative court level. The possible complexities have not been considered but certainly have to be entertained in the scheme of this doctrine.

The logic behind the doctrine is, however, probably valid. In a delivery-of-care mechanism where people are unable to obtain care, this delivery would be guaranteed as an access to the finest treatment available and accomplished without question. Since the state and its tax base would pay for that care, any subsequent damage which might result, assuming there is fault, could certainly have adjudication rendered by an appropriate administrative hearing, and the restitution, should it be desired, accomplished within a 60-day time frame. Since the cost of care and payment to the treating institution and physician are from tax money, then should not also tax money compensate the individual involved? Since all segments of society contribute in taxes, should they sue themselves to support a system which currently takes 72% of the premium dollar in administrative cost, court and expenses which are paid by the people for capitated care?

The important fallout is that in a significant number of cases with relative limitation of payment of damages a reflection of a significant decrease has occurred in the frequency and severity of potentially large awards continually promulgated under the current system. Since this may represent 30% to 35% of all potential litigants, it would seem a significant reduction in premiums for liability insurance would recur to those covered by the doctrine. These, of course, are those who care for patients who fall in this indigent category and the ethic of not suing the Good Samaritan is one which civilized people everywhere seem to adopt. It would also seem that there could be some significant reduction in the frequency and, thereby, the cost of defensive medical tests and studies engendered by this group of patients. The cost savings would be considerable considering the reduction of defensive procedures and the overall liability premium paid by those physicians involved in this type of care.

Prospective studies seem to be in order to determine what and how much these dollar amounts are. It would appear that the alleged 28% of the premium dollar now returned to the patient would be increased. It also would appear that the alleged 72% of the dollar required to fuel the current system would be reducible by perhaps 50%.

Codification of the ethics of care in this group especially would need examination and study by academicians. The quality of care need not and should not be abrogated, but the savings to the insurers who are the citizens of the state and nation would be significant. The amount paid by the recipients regardless of their financial status would deliver better quality care at less cost assuming there is widespread cooperation in the system.

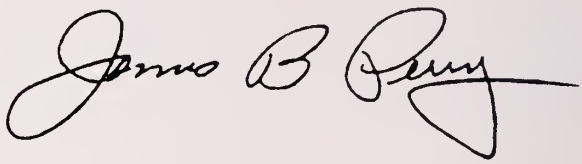
We must begin someplace. Perhaps the Good Samaritan portion of the trauma network is a beginning. It could be extended to include indigent patients. Add to this Medicaid patients and Medicare indigents and in due course all of Medicare. It is obvious that a huge segment of the population falls into this group. Later, all insureds on a voluntary contractual basis could be included and sooner or later the doctrine could impact the entire third party reimbursable care spectrum leaving only the totally uninsured out on a limb. They certainly would elect to be a participant before too long.

This type of innovation would conceivably defuse the professional liability crisis and the cost of medical care would be significantly reduced.

The possibility of this extending to other segments of society, though not absolute and fraught with obstacles, would be an addressable issue by those in leadership positions.

The support of every physician, legislator and, truly, every citizen of this state is needed to accomplish this undertaking. Admittedly it is a bit altruistic, but then many plans of this scope are. The physicians of Florida represented by this Association and all society could benefit and be in a much better condition than they seem to be at this current writing.

Your thoughts, interests and input are needed and participation by our colleagues and all the support systems, be they free standing hospitals or offices, is hereby requested. God bless you for your time, consideration and objective viewpoints.



GET MORE FOR YOUR ADVERTISING DOLLAR

Purchase A Display Ad in the

Journal of the Florida Medical Association, Inc.

Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203

(904) 356-1571

Hepatobiliary Diseases in Clinical Practice VII

February 19-21, 1987, Sheraton Bal Harbour, Florida

Sponsored by: University of Miami School of Medicine, Division of Hepatology

Course Directors: Eugene R. Schiff, M.D., F.A.C.P.
Leon Schiff, M.D., Ph.D., M.A.C.P.

Guest Faculty

W. Scott Brooks Jr., M.D.
Emory Univ. School of Med.
Atlanta, GA

JeanPierre Delmont, M.D.
Universite de Nice
Nice, France

Jules L. Dienstag, M.D.
Harvard Medical School
Boston, MA

Marshall M. Kaplan, M.D.
Tufts Univ. School of Med.
Boston, MA

Jay H. Lefkowitch, M.D.
Columbia Univ. College of Physicians and Surgeons
New York, NY

Frank G. Moody, M.D.
Hermann Hospital
Houston, TX

David H. Van Thiel, M.D.
University of Pittsburgh School of Medicine
Pittsburgh, PA

The course is directed toward internists, gastroenterologists, alimentary tract surgeons, hepatologists and other physicians, residents, nurses and allied health professionals who deal with these complex patients and issues. Didactic presentations will be augmented with extensive audiovisuals, panel discussions, workshops, and question/answer sessions.

Course Hours: 12.0 Category I AMA

Course Fees: $325 Physicians in practice; $395 after January 1, 1987; $200 Residents/Allied Health Professionals

For Further Information: Division of CME D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami, FL 33101, (305) 547-6716

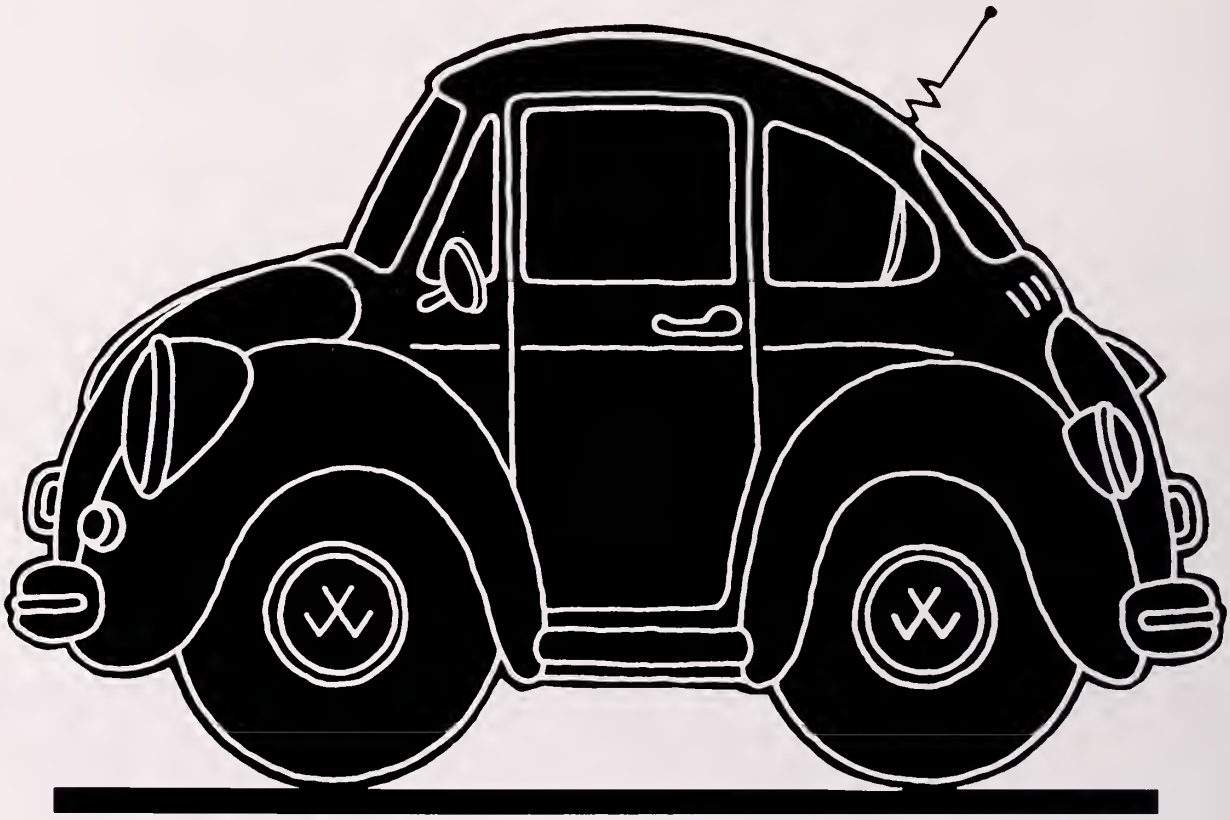
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg Buccal/10 mg Oral/25 mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg





Finally, A Phone For The Economy Car.

It's the BellSouth Mobility car phone. And it's now the most affordable and reliable phone on wheels–no matter what car you drive. That's why BellSouth Mobility has put more phones in more cars than anyone in the Southeast.

Our car phone is just as easy to use as the phone in your home. In fact, it's really like having another extension–only this one goes 55 miles per hour. So call BellSouth Mobility for full details today at **1-800-351-3355.** Because all the way from Jupiter to Florida City, we really are the phone company for your car.



The Phone Company For Your Car.℠

BellSouth Mobility

A *BELL*SOUTH Company

©1986 BellSouth Mobility

Freedom to practice slipping away

The precious freedom of physicians to practice medicine unencumbered by outside interference is perilously close to becoming a thing of the past. Bit by bit, slowly but surely, physicians have been surrendering the prerogatives of their profession to assorted third parties by default. As physicians lose power, the government, big corporations, and insurance companies become more dominant and increasingly are calling the shots.

It was not long ago when physicians were trusted to take care of their patients, and this included doing necessary diagnostic tests, planning courses of treatment, and calling other physicians for consultations when needed. If certain patients needed to be put in the hospital, that judgment was respected. And this was true for other myriad matters related to the practice of medicine and the care of patients. But contrast that with the scenario today: most physicians, at one time or another, will be asked to contact a third party (usually an insurance company, an HMO, or the state PRO) before they can admit patients to hospitals, required to justify everything they do, scrutinized for their practice patterns, harrassed by cold-blooded third-party inquisitors, and even occasionally denied payments for their services. It is a stark picture, with no prospect that relief will be coming soon.

It seems strange and perplexing that these indignities are being foisted on a profession whose members earn the highest public respect, year in and year out, for their dedication, integrity, and competence. The rigorous intellectual discipline and the exacting years of training demanded of today's physicians should equip them with the ability and probity to make trustworthy judgments without the onus of having to prove everytime that their actions are motivated by economic considerations. There are a few incompetent and dishonest physicians; disciplining and even jailing some of them is what the government and other third parties, in concert with the medical profession, should be focusing their efforts on. The paradox of third-party intrusion into medicine is that physicians have been unfairly singled out by discriminatory regulations even while lawyers, politicians, accountants, and a host of other professionals continue to enjoy their traditional freedom.

The overwhelming concern about the high cost of medical care no doubt led to the need for some measures to reform an expensive system. While physicians feel morally obliged to support such measures, they never expected that they would be used as sacrificial lambs in the process. Nobody ever expected that the reformers would be so zealous that, in their all-consuming passion to contain costs, they would be abridging physicians' freedom to practice and jeopardizing the quality of patient care. The government and other parties may have saved a little money with their strangulating regulations, but to do so by curbing the freedom of physicians to treat their patients is odious and inexcusable.

Review processes put in place because of DRGs and other cost constraints are a classic example of why physicians are so frustrated with the new system. Cookbook medicine is the new game in town, but most physicians find it hard to believe that this is the type of medicine they were taught in medical schools and in their residency training. Pigeonholing patients according to their illnesses into neat categories is in itself not objectionable, but making crucial clinical decisions on patients on the basis of bureaucratic criteria and questionable peer reviews is another matter. The inept performance of the PSROs in the 70s and now of the PROs, with all the problems engendered, should mobilize physicians to demand that the practice of medicine should be left to physicians alone.

It may be argued that the government and other

third-party payors have every right to institute regulations in an area where the annual costs are close to 12% of the gross national product. True, and physicians are equally concerned about this. But to save money by stripping physicians of their ability to make decisions on their patients and dictating what they need to do is an insult to them and a mockery of their profession. Physicians must be beholden primarily to their patients and their interests, not to the government, HMOs, hospitals, or insurance companies whose motives may be entirely different. Further usurpation of physicians' freedom to practice will speed the day when socialized medicine will be at our doorsteps. If it finally comes, Americans will forever rue that day.

R. G. Lacsamana, M.D.
Editor

Thoughts on Thanksgiving

With roast turkey, cranberry sauce and pumpkin pies, of all the holidays observed in this country, there is none so distinctively American as Thanksgiving, a legacy of the Pilgrims cherished because of the traditions attached to it.

Enjoyed not only by descendants of the Pilgrims but by all Americans, Thanksgiving is a time for grateful acknowledgement for our material prosperity, our homes and families and for all the blessings the year has brought.

During the first dreadful winter spent by the Plymouth colonists in Massachusetts, half of them died from cold and starvation, but with spring came new hope. A friendly Indian taught them how to plant corn, barley and peas. Fall brought abundant crops and a day of thanksgiving was celebrated in December 1621 with rejoicing and renewed faith that they might continue to live in this new land with freedom to work and worship and the right to govern themselves. The women spent days preparing for this feast and the children were kept busy turning roasts on spits in front of open fires. More than 80 Indians came bringing wild turkeys and venison. The tables were set outdoors and for three days the people celebrated with prayers, sermons and songs.

Two years later in the summer of 1623 the Pilgrims again faced starvation, for this had followed another gloomy, cold winter. Hopefully, however, in the spring seeds were planted, but a severe drought followed in May and almost destroyed the crops. Governor Bradford, therefore, ordered a day of fasting and prayer. After nine hours of prayer, small clouds appeared in the sky and then came a long refreshing rain that saved the crops. To show their gratitude to God the Pilgrims set aside a day of thanksgiving on November 23, 1623 and Governor Bradford issued a proclamation to gather at the meeting house. This custom spread from Plymouth to other New England colonies and was observed during the Revolutionary War. Then, on November 26, 1789, George Washington issued the first presidential proclamation for a day to honor the adoption of the consititution, " . . .a form of government that would make for safety and happiness." Observed sporadically by other Presidents, it was almost 100 years later that after the depressing first and second years of the war between the states, there occurred the victory at Gettysburg and President Lincoln issued a proclamation setting aside the last Thursday of November as a day of thanksgiving and to fervently implore "the interposition of the Almighty hand to heal the wounds of the nation, to the full enjoyment of peace, harmony and union."

Every year afterward for 75 years Presidents have followed suit until 1939 President Roosevelt advanced the celebration a week earlier. Congress, in 1941, however, decided that the fourth Thursday should again be our official Thanksgiving, and so it was returned to the original day selected by our first President.

Thus, from our earliest recorded history Americans have in our deepest natures, in our very souls, like all mankind since earliest times felt the presence of a Supreme Being and experienced a thankful reflection on the goodness of God the giver, a deep sense of our own unworthiness and a recollection of the uncertainty of our long possessing these earthly blessings.

Aware that an old custom without truth, but an old error and aware that goodness is achieved not in a vacuum but in the company of other men, attended by love, and realizing that our own worth consists in what we are and not what we have, for what we are will show in what we do, this Thanksgiving we are grateful that our government stands for justice and

independence for all men, including free speech and free action within the limits of law, of obedience to law, of universal education, of material wellbeing for all the wellbehaving and industrious, of peace and good will among men.

Far short, however, we may fall in expressing this in actual life today, these dictums are — no one will deny it — the ideals of our American democracy.

Clyde M. Collins, M.D.
Contributing Editor
Jacksonville

Ethics in medicine

Ethics is truly a personal matter, personal in the sense that it arises from a personal concern for one's conduct. It is also personal in the sense that one's conduct is self-directed and self-enforced; the person voluntarily follows a code of conduct because he feels it is the thing to do. Ethics is predictive in that it serves as a guide for conduct and indicates pretty well what one can be expected to do in a certain situation, and it is rational in that reason dictates its acceptance.

Physicians must care about ethics; they should not be amoral or nonethical in their activities. The person in medicine (like any person) needs to have values and standards for himself — rationally arrived at and rationally enforced. Ethics — at least a concern for ethics — instills in the physician a continuing sensitivity to his every action, to his every decision; it integrates or blends with his total search for truth, and it gives him greater awareness of himself, of others, of the consequence of interpersonal relations. A concern with ethics is the key plank in any medical platform to improve the physician's fading image; it is the "alpha and omega" of public communication.

Like so many of other important and complex subjects, ethics is looked at from a number of perspectives. There are numerous ways of classifying and analyzing ethical theories and systems; names and labels have proliferated as philosophers have ranged the frontiers of moral philosophy down through the years, seeking new insights and forming new schools. The key aspect of ethics is self-enforcement or self-legislation.

It is the belief of the writer that all the many theories and systems of ethics can be accommodated in the concept of the ethical dialectic with the three basic systems of legalistic, antinomian and situation ethics.

Legalistic ethics is the absolute or objective ethical system based largely on tradition, on social agreement or a firm religious moral code. Legalistic ethics is rational in that it is pragmatic, socially beneficial and personally comforting. Legalistic ethics is consensus ethics in that a person is ethical or unethical to the degree that he conforms to, or deviates from, the norm or codes of his society. Legalistic ethics is basically an absolute system, a rigid system, not permitting for very much permissiveness and rationalizing. Right is right and wrong is wrong.

Rebels reacting negatively to the constrictions and absolutes of code ethics have accepted what has been called antinomian (against law) ethics. The antinomian is against standards and thinks he needs no directions or rules. He wants no guide other than his senses, his existential intuitions and instincts.

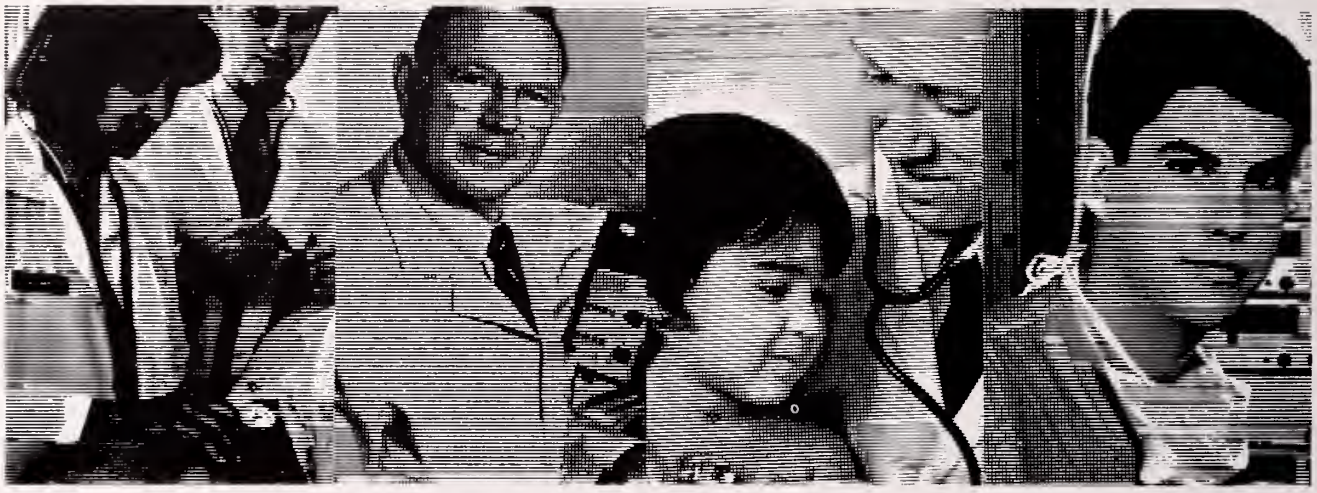
There is a middle ground between legalistic and antinomian ethics called situation ethics. The situationist is guided generally by the traditional code of ethics because of its universal appeal and relevance but his is not tied tightly to any ethical rules. He breaks them when he thinks there is a need to do so. It appears to the writer that today the majority of American journalists subscribe to the situation ethical position.

Ethics is an extremely complex subject. The only kind of moral judgments that have any lasting validity are absolute ethical standards. No subjective theory of ethics, which in reality washes away the whole concept of objective standards, should ever be taken very seriously by rational men.

The moral physician is he who observes those rules of just conduct which have been defined by the traditions and codes of the medical society to which he belongs. Morality cannot be a fixed attribute as nothing in life is beyond change. Morality continues as our expanding awareness.

Edward Pedrero Jr., M.D., Ph.D.
Contributing Editor
Tampa

FAMILY PRACTICE. A REWARDING EXPERIENCE IN ARMY MEDICINE.



THE ARMY RESERVE IN THE SOUTHEAST NEEDS PHYSICIANS WHO SPECIALIZE IN FAMILY PRACTICE, TO JOIN AN EXCEPTIONAL TEAM.

WE UNDERSTAND THE DEMANDS ON A BUSY PRACTITIONER. SO WE'RE FLEXIBLE ABOUT TIME, PARTICULARLY WHEN IT'S TIME YOU WANT TO SHARE WITH YOUR COUNTRY.

IN THE ARMY RESERVE, YOU'LL FIND OPPORTUNITIES THAT ARE CHALLENGING AND VARIED. OPPORTUNITIES TO PARTICIPATE IN EXCITING TRAINING PROGRAMS AND WORK WITH OUTSTANDING PHYSICIANS FROM EVERY AREA OF THE COUNTRY AND TO EXTEND ASPECTS OF YOUR SPECIALITY. WE THINK A FIRST PHONE CALL COULD PROVE TO BE REWARDING.

THE ACTIVE ARMY HAS MORE SOLDIERS WITH FAMILIES THAN EVER BEFORE. SO WHEN YOU JOIN THE ARMY MEDICAL TEAM AS A FAMILY PRACTITIONER, EXPECT TO SPEND MOST OF YOUR TIME SERVING NOT ONLY SOLDIERS, BUT THEIR SPOUSES AND CHILDREN, TOO. WHAT'S MORE, YOU WON'T HAVE TO WORRY ABOUT THE PAPERWORK, MALPRACTICE INSURANCE PREMIUMS, OR THE COSTS INCURRED IN RUNNING A PRIVATE PRACTICE.

WORKING WITH A TEAM OF HIGHLY TRAINED PROFESSIONALS, YOU CAN RECEIVE ASSIGNMENTS ALMOST ANYWHERE IN THE U.S. AS WELL AS OVERSEAS. PLUS UP TO 30 DAYS OF PAID VACATION AND REASONABLE WORK HOURS.

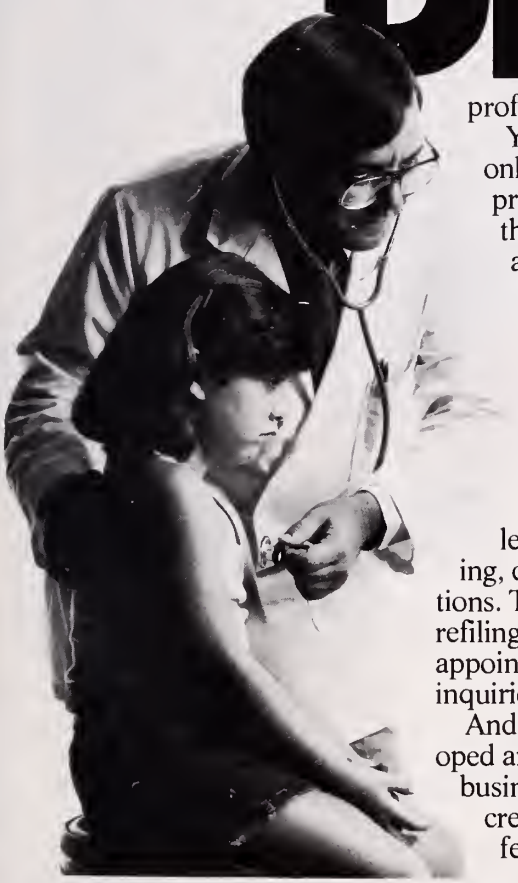
ALL IN ALL, YOUR ARMY FAMILY PRACTICE WILL BE A REWARDING EXPERIENCE.

TALK TO YOUR LOCAL U.S. ARMY OR ARMY RESERVE MEDICAL DEPARTMENT COUNSELOR FOR MORE INFORMATION ON FAMILY PRACTICE IN THE ARMY.

ARMY/ARMY RESERVE MEDICINE
3101 MAGUIRE BLVD
ESSEX BLD, SUITE 166
ORLANDO, FL 32803
CALL COLLECT: (305) 896-0780

ARMY. ARMY RESERVE. BE ALL YOU CAN BE.

THE PATIENT RECOVERED. THE PHYSICIAN DIDN'T.



Of all the recoveries you face, the recovery of income can be the hardest of all.

Staggering Medicare, HMO and other insurance paperwork requirements can tie up your cash flow— and restrict the profitability of your practice.

You need a system that will not only speed along the collections process, but one that will increase the financial efficiency of *every* aspect of your practice—from filing claims to scheduling patients. You need Quick Recovery.™

QUICK RECOVERY. DEVELOPED BY PHYSICIANS FOR *PHYSICIANS.*

Utilizing the IBM System/36, Quick Recovery lets you automate your entire billing, collections, and operations functions. The filing, tracking and automatic refiling of insurance claims. Even appointment scheduling and patient inquiries.

And unlike systems that are developed and then adapted to different businesses, Quick Recovery was created specifically for medical professionals, *by* medical professionals.

Through our affiliation with the Sacred Heart Health System, we developed Quick Recovery by working closely with physicians and health care professionals. The result? A totally computerized office management system ideal for today's single and multi-practice offices.

GIVE YOUR OFFICE A QUICK RECOVERY CHECKUP.

To find out more about Quick Recovery and how it can benefit your practice, call Gulf Coast Diversified, Inc. toll free at 1-800-874-1026 (1-800-342-1014 in Florida,) or fill out the coupon below. We'd be happy to give your office a no-obligation Quick Recovery checkup.

Don't wait. It's time you put your practice on the road to recovery.

YES, I'm interested in a no-obligation Quick Recovery checkup.

Name_____

Address_____

City/State/Zip_____

Specialty_____

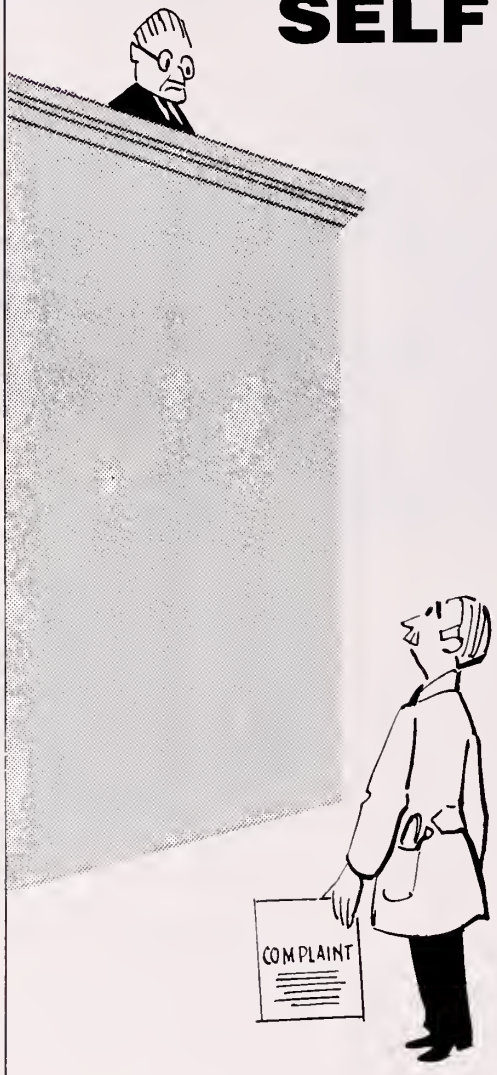
Office phone (_____)_____

Best time to call____:____ am pm

GULF COAST DIVERSIFIED, INC.
5130 Bayou Blvd.
Pensacola, FL 32503
An affiliate of
Sacred Heart Health System

IBM
Authorized Value Added Remarketer
System 36

GOING BARE?
SELF INSURED?



New Florida law gives health care providers malpractice insurance options never before available.

First Defense can now offer low cost legal defense insurance which makes "going bare" or being "self-insured" a practical alternative to malpractice insurance.

High limit standard malpractice insurance should be your first choice. However, many professionals aren't able to afford such coverage. If you have decided not to purchase standard medical malpractice coverage, you still need your assets and license to practice protected. First Defense is the only licensed insurance corporation in the State of Florida that can provide legal defense insurance of this kind.

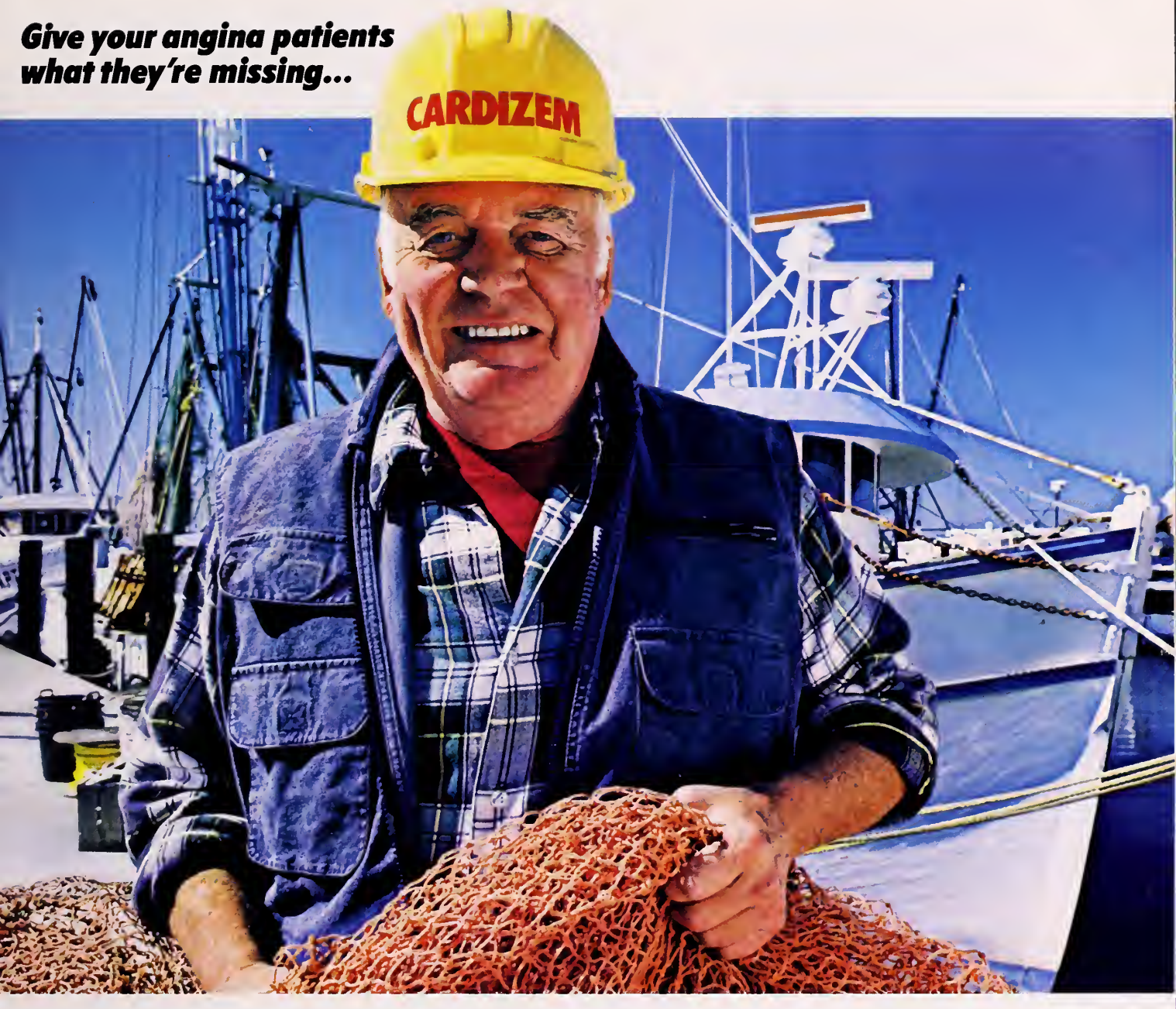
Special DPR coverage to handle all legal costs and attorneys fees of the Department of Professional Regulation investigation and prosecutions is also available for $250.00 a year.

Call or write First Defense Legal Services Insurance Corporation, 1350 Southwest 57 Avenue, Suite 208, Miami, Florida 33144 - Telephone (305) 264-8722.

First Defense
Legal Services Insurance Corp.

1350 S.W. 57th Ave., Suite 208, Miami, Fl. 33144 - Ph. (305) 264-8722

Give your angina patients what they're missing...



CARDIZEM®: FEW SIDE EFFECTS

diltiazem HCl/Marion

- ***Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate***
- ***Proven efficacy when used alone in angina[1]***
- ***Compatible with other antianginals[2,3*]***
- ***A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD[4,5]***

***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.



CARDIZEM® FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

diltiazem HCl/Marion

60 mg tid or qid

Brief Summary
Professional Use Information
CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets
CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).
WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphotase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*
Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*
Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.
Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*
Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*
There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.
Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*
Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.
In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.
The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 11/85*
See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***3.*** *Johnstan DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranalol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

Another potent benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137

0088M6

More family physicians needed in Florida

The development of Family Practice in Florida has occurred as a response to a variety of factors, national and local.

Seventy-five years ago most physicians were family doctors and most families were happy with a physician they could turn to for all medical care. The doctor was considered as one of the family and had the pleasure of watching successive generations grow and prosper. After the first World War the publicity concerning the accomplishments of multispecialty clinics and the ever-increasing expertise of medical and surgical specialists convinced the American citizen that only the expert was qualified to provide adequate care.

In Florida, this process was further complicated by a unique effect of medical demographics. During the "Great Depression" few young people left the state, which had no medical school, for medical training and fewer still returned here to practice. After World War II the dedicated band of physicians who had been providing care for many years was rapidly decimated by death and retirement. This vacuum was rapidly filled by an influx of postdepression Floridian physicians and many who had enjoyed military service in Florida. But the effects of the professional generation gap caused by the Depression and the war are felt to this day.

The postwar period saw the development of community hospital internships and residencies in Pensacola, Jacksonville, Miami, Orlando, Tampa, and St. Petersburg. The first medical school was founded at the University of Miami followed shortly by the University of Florida at Gainesville and in 1968 by the College of Medicine at the University of South Florida in Tampa. The increasing emphasis on specialty training was felt throughout the medical education community and although many entered practice as G.P.s after one year internships, a majority went on to specialty residencies and certification.

Concern over the rapidly fragmenting provision of medical care prompted the Trustees of the American Medical Association to sponsor an external review of medical education as it related to the provision of care in America. The prestigious Citizen's Commission on Graduate Medical Education became known as the Millis Commission after its Chairman, John Millis, M.D., President of Western Reserve University. The Commission report submitted in August 1966 should be required reading by anyone interested in medical education and the delivery of medical care. Many of the present ACGME requirements are based on the Millis Commission findings.

The recommendations of the Commission relating to Family Practice address the need for physicians "who will have the desire and the qualifications to render comprehensive, continuing health services, including preventive measures, early diagnosis, rehabilitative and supportive therapy, as well as the diagnosis and treatment of acute or episodic disease states."

To accomplish these goals the Commission recommended that the training of this "primary physician" should:

- include knowledge and skills in several areas of medicine.
- include experience in emergency medicine and the pre- and postsurgical care.
- include a new body of knowledge relating to people as well as their diseases and pathology.
- involve a program of training as long and as intensive as any other specialty.

The Millis Commission report provided the stimulus to speed up the ongoing discussions of the American Academy of General Practice with other

specialty societies and the LCGME with the result that Family Practice was approved as the twentieth medical specialty in 1969. As a new specialty Family Practice was not bound by generations of academic tradition. Innovations such as mandatory recertification and required continuing medical education were instituted from the beginning. The American Board of Family Practice included representatives from other specialties and the residencies for Family Practice are based on an ambulatory care model rather than the traditional hospital-based training.

The concept of Family Practice was a seed that found fertile soil in Florida. The large retired population remembered the "Family Doctor" of the past and the mystique of the far away specialist was not as appealing as it had been. The residency at the University of Miami, based on a primary care program founded by Dr. Lynn P. Carmichael, Miami, was one of a dozen University programs awarded initial approval in 1969. Within the next three years residencies were approved in community hospitals in Daytona Beach, Jacksonville, St. Petersburg, Tallahassee, Gainesville, and Orlando.

Each of Florida's medical schools has active Family Medicine programs and the State Legislature, acknowledging the importance of primary care, has provided some funding for the primary care specialists of Family Practice, General Internal Medicine, and Pediatrics in community hospitals. The Florida Academy of Family Physicians has been an outstanding supporter of Family Practice education in the medical schools as well as the residencies. The nine civilian and three military residencies now graduate 75 Family Physicians in Florida each year.

Student interest in Family Practice has been high from the beginning with competition for the 385 residencies from students in the upper academic brackets of their class — contrasted with the students who only wanted one year internships in years past. With the changes in interest charges and the difficulty in securing student loans for medical school, there was a slight drop in applications recently but with the increasing importance of the residency-trained Family Physician as "gate keeper" in today's capitation care plans the interest is again high as students see the increasing difficulties in finding programs in other specialties perceived as more attractive financially.

But the specter of the generation gap is still with us. The physicians coming to Florida after the war are now reaching retirement age. A study by the Florida Academy of Family Physicians in 1986 predicts that by 1989 there will be more practices terminated by death or retirement than new practices started. In order to maintain an acceptable ratio of Family Physicians to the increasing population 200 new doctors will be necessary each year, considerably more than the Florida programs graduate. Federal, state, and private funding for new residencies is increasingly difficult and expansion of present programs limited by lack of available facilities and funding.

The next ten years will see an increased emphasis in primary care and particularly Family Practice. Trained in the ambulatory care setting, qualified to diagnose and manage the large majority of problems presented to him, sophisticated in his use of consultations and ancillary help, the residency-trained Family Physician can practice successfully in any medical environment. Hospital practice is already decreasing and the medical schools themselves are addressing ambulatory care with increasing acceptance of Family Medicine in the curriculum and student rotations. The generation gap will close and a stable, balanced medical community will come to pass.

Charles E. Aucremann, M.D.
Professor and Chairman
Department of Family Medicine
University of South Florida
College of Medicine
Tampa

Eye-catching errors

The August, 1986 issue of *The Journal of the Florida Medical Association* highlighted sports medicine, a very important and rapidly growing subject. The article "Ocular Injuries in Sports" by Marcos T. Doxanas, M.D., was an interesting one and obviously directed toward the non-ophthalmologist. However, there were several errors and glaring omissions which bear mentioning.

To begin with, the article goes into great detail on the subjects of myopia and hyperopia, but completely fails to mention astigmatism and its effects upon athletes.

Paragraph three refers to "patients with large refractory (sic) errors;" I believe the author is referring to refractive errors, or errors of refraction.

The ensuing paragraph addresses the subject of "radial keratometry (sic)," whereas the correct terminology is radial keratotomy. The conclusion that radial keratotomy and other forms of refractive surgery should be "discouraged in any athlete" is not a view which is universally held by ophthalmologists.

Great detail is given to the diagnosis of corneal abrasions, with no mention of proper treatment. Likewise, there is a lengthy dissertation on the subject of foreign bodies of the upper eyelid, but no mention of the far more common corneal foreign bodies.

Alkali injury is discussed, but I hardly think this qualifies as a sports related injury.

The subject of orbital and eyelid trauma is well covered, although the author uses the term "anophthalmos" twice in paragraph eight, whereas I believe the appropriate term is enophthalmos.

The subject of hyphema, its significance, and the necessity of prompt ophthalmologic referral in order to avoid acute and longterm ophthalmic side effects, is totally omitted. Unfortunately, failure to diagnose a hyphema at the time of initial examination could prevent a patient from seeking appropriate ophthalmologic consultation, resulting in serious potential medical and medicolegal problems.

Proper pupillary examination techniques in ocular, facial, and cranial injuries, is totally disregarded.

Finally, there is no mention made of the importance of ocular lacerations, perforations, or ruptures which are certainly the most potentially serious ocular injuries occurring in sports. The role of prompt neurosurgery, vitrectomy, suturing, antibiotics, and steroids, including the tremendous improvement in modern techniques and visual outcome, certainly merited some mention in this article.

The conclusion that eye protection is recommended certainly deserves more prominence in any discussion of ocular injury, as the prevention of injuries is far more desirable than even the most effective treatment.

Nevertheless, the article is certainly timely and appropriate.

R.G. Shugarman, M.D., F.A.C.S., F.I.C.S.
Clinical Instructor
Bascom Palmer Eye Institute
University of Miami
School of Medicine
Chief of Ophthalmology
JFK Memorial Hospital
Atlantis

Doctors in catch-22 situation

I wanted to tell you how much I enjoyed your editorial in the August issue of the *JFMA* entitled "Medicare in Troubled Waters." I felt that this really "hits the nail on the head!"

Unfortunately, I am not sure that anyone will listen, or care, to address the plight of the physician. However, ultimately, the public will pay the price as we are already seeing significant drops in numbers of applications for medical school, particularly in the private sector (but also noted in public schools such as University of Florida). This will mean a lower quality of physician and, thus, the quality of care will be "diluted." Quite frankly, I cannot really blame the applicants, since all they see ahead are the storm clouds of increased bureaucracy and paper work, and a "catch-22" situation whereby doctors are caught in a squeeze between being sued on one side and being the "gate keeper" and "monitor" of medical costs. Certainly, we must never lose sight of our responsibility to deliver quality patient care, but it is becoming increasingly more difficult to do this and we are even faced with the possibility of being put in a situation of becoming "servants" to the state such as has recently happened in Massachusetts.

Perhaps this is the time to consider more "drastic" measures, such as a "march on Washington," organized on a national scale perhaps by the AMA?

Many thanks again for your incisive and cogent remarks concerning our present state.

Francis A. Reed, M.D.
Deland

Mayo Clinic and indigent care

I note with interest the recent article in October 17, 1986 issue of the *American Medical News* in which Mayo's C.E.O., Dr. D. Thane Cody, states that Mayo "does not accept any kind of insurance program," and the patient "must pick up the remainder (of the bill that is not covered)." One must conclude that the unfortunate indigents can therefore not avail themselves of this "tremendous team of physicians."

I would imagine that the physicians in the greater Jacksonville area must be ecstatic with the advent of this new facility which competes with them for pay patients and the heavily insured, but still reserves for them the joy and the privilege of serving humanity, at least the indigent segment of northeast Florida's population.

John W. Morris, M.D.
Daytona Beach

Fighting drug abuse

I read your excellent article, "The Drug Problem: Tilting With Windmills," in the August issue of *JFMA*. I share your ideas about the solutions to this problem.

Informed Families of Dade County was founded by volunteers who are concerned with drug abuse by our children. I am enclosing our brochure "What If?" and invite you to learn more about our work in the community.

There is a way to fight against drug use and abuse. It is by becoming educated and united against substance abuse, teaching prevention in our schools, and educating children and adults about the consequences of abusing their bodies.

I would love to read in the coming issues of the *JFMA* your ideas about organizations like ours. We need educated and concerned people like you to unite with our forces and work hand-in-hand to give our children a society without drugs, prostitution, pornography, crime, etc.

God works through us, so his miracles have to come through us. We have made mistakes, but we can also correct them.

Eysa Rojas
Hispanic Task Force Director
Coral Gables

Windsurfing: kill or save the sport?

I must take issue with the recent issue on windsurfing injuries by B.M. Habal, M.D., that appeared in the August, 1986 issue of *The Journal.* While injuries undeniably do occur, no inference can be drawn from the evidence presented as to the risk of injury per unit exposure. Furthermore, when viewed as a public health problem, many other water sports, (water-skiing, for example), produce far more injuries and deaths than does boardsailing, but remain totally unregulated. The draconian measures proposed by Dr. Habal seem more likely to kill the sport than to prevent injuries, and certainly would produce widespread disdain for the law, e.g. licensure required for boardsailors and not power-boat operators?

A more reasonable approach would be to convene a group of physicians, boardsailors, and manufacturers who might jointly approach the problem of preventing injuries in boardsailing through a combination of improved design, sailing technique, and lastly, regulation. For example, a redesign of the footstrap may do much more to reduce the risk of knee injury than will a legislated requirement for a knee brace. A cooperative, rather than a mandated approach will prove more effective in the long run.

Robert L. Wears, M.D., F.A.C.E.P.
Assistant Professor
Division of Emergency Medicine
Department of Surgery
University Hospital of Jacksonville
Jacksonville

New Florida law: an addendum

Subsequent to the submission of the article "Legality of physician referral of patients to health care facilities owned by the referring physician," published in the September, 1986 issue of *The Journal*, the Florida legislature enacted a law to govern this very situation. Paragraph (qq) has been added to Section 458.331 of the Florida Statutes, effective October 1, 1986, to mandate that if a physician who has an equity interest of ten percent or more in a business entity refers a patient to the business entity for health care goods or services, then the physician must notify the patient of his financial interest and of the patient's right to obtain such goods or services at the location of the patient's choice. The statute does not apply however, to the following types of equity interest:

1. The ownership of registered securities issued by a publicly held corporation or the ownership of securities issued by a publicly held corporation, the shares of which are traded on a national exchange or the over-the-counter market;
2. A physician's own practice, whether he is a sole practitioner or part of a group, when the health care good or service is prescribed or provided solely for the physican's own patients and is provided or performed by the physician or under his supervision; or
3. An interest in real property resulting in a landlord-tenant relationship between the physician and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant, or otherwise unrelated to fair market value.

John Michael Register
Leon J. Wolfe
Tampa

Bravo!

I am compelled to write and congratulate you on your admirable editorial, "Language Pollution in Medicine," in the September issue of the *JFMA*. Words are so important and you marvelously succeeded in lacing your philippic against the Philistines with a delightful wit!

Henry J. L. Marriott, M.D.
Director, Clinical Research
The Rogers Heart Foundation
St. Petersburg

Rabies antibodies a fascinating puzzle

The article "Survey of raccoon hunters for rabies antibody titers: pilot study" by Drs. Black and Wiktor that appeared in the *JFMA*, July 1986, presented interesting findings and interesting ideas.

The authors speculated on possible explanations for the presence of rabies virus neutralizing antibodies in persons who had had substantial contact with

raccoons via hunting, skinning, preparing for consumption, or consuming raccoons. It is a fascinating puzzle that begs to be explained. I hope that Black and Wiktor or others will pursue further studies. Specifically, their suggestion to administer rabies vaccine to the persons who showed apparent rabies virus neutralizing titers and then monitor further titers for anamnestic response seems to be a straightforward way to proceed: such testing would presumably differentiate between rabies antibodies and some confounding substance that causes a laboratory reaction in serum which really has no true rabies antibodies.

For the present, one should regard Black and Wiktor's article as a report of a laboratory finding which needs to be investigated. Any implication that raccoon hunters, commercial skinners, etc., develop some protection against rabies must not be accepted without much more evidence. Accordingly, one must not reduce vigilance and respectful fear of potentially rabid animals. One must not fail to use rabies immune globulin and rabies vaccine according to time-tested guidelines.[1]

Sylvatic rabies (that is, rabies in wild animals) is a much more prevalent thing than Black and Wiktor's paper suggests. They have quoted a figure of 7,211 laboratory confirmed cases of animal rabies reported in the United States during a 20-year period. In point of fact, the figure 7,211 is for one year alone (1981).[2]

References

1. Immunization Practices Advisory Committee (ACIP), MMWR 33:393, 1984.
2. Centers for Disease Control, Rabies — United States, 1981, MMWR 31:379, 1982.

John J. Benton, M.D.
Public Health Unit Director
HRS
Panama City



How Outdoor Lighting Can Strengthen Your Security

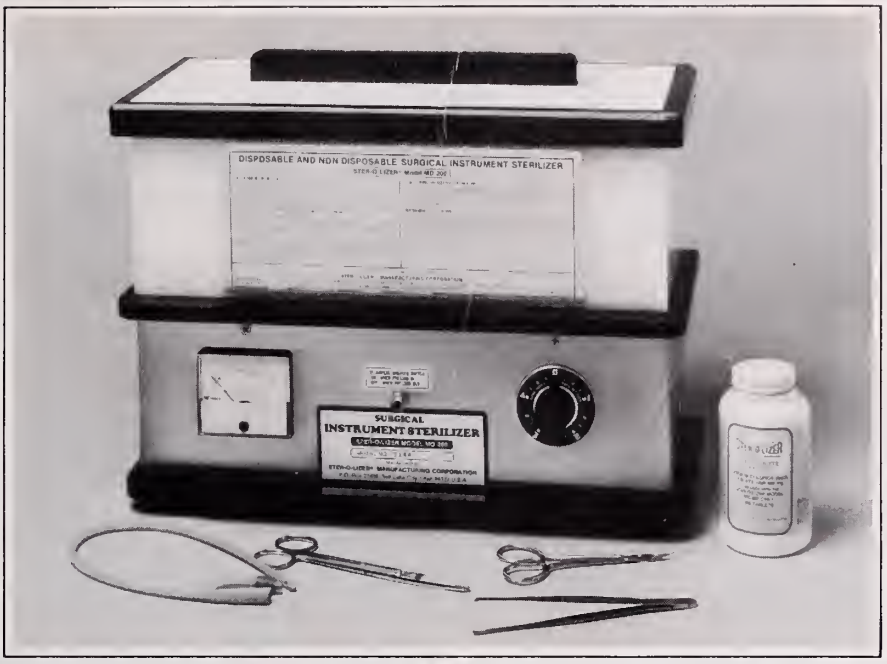
Outdoor lighting will make you, your customers and employees feel much more secure. ▪ Experts affirm that burglary and vandalism drop dramatically after outdoor lighting is installed. And it costs less than security personnel, guard dogs and alarm systems. ▪ Our Energy Experts can help you add this powerful protector. If you're a Florida Power Corporation customer, we'll visit your business, recommend a lighting plan and help you choose both the fixtures and a contractor. Then we'll supervise the installation. ▪ We'll even work out extended payments—one year for a single fixture, two years for more than one. With no added charges. ▪ Call John McCary, Lighting Program Coordinator, at 800-445-3320 toll free for information on outdoor lighting. Protect your business with a strong, silent type.

Florida Power
CORPORATION

Call the Energy Experts at 800-445-3320

This is the equipment that medical experts described as

"... THE MOST IMPORTANT SURGICAL INSTRUMENT STERILIZER EVER INVENTED..."



The **STER-O-LIZER MD-200** sterilizes all types of surgical instruments, disposables and non-disposables, in 2 minutes, and without gas, heat or chemicals.

The instruments can be used immediately upon sterilization - no waiting!

How the **STER-O-LIZER MD-200** works:

It is a cold sterilizer. It uses distilled water and chemically pure salt (NaCl) tablets provided.

When this light brine solution comes in contact with the multi-patented anodes, it is converted into ozone, nascent chlorine and their respective free radicals.

Working synergistically, they are the most powerful germicidal agents known!

The STER-O-LIZER MD-200 has been advertised in all major medical journals of the world. It has also been exhibited in many national and international medical conventions.

Not only does it sterilize instruments, but its solution is used to wash/sterilize hands, poured on open cuts, wounds and burns without the slightest burning sensation to patients. Dentists are using it to eliminate plaque and to cure gingivitis.

HERE IS A VERY SPECIAL OFFER! 100 UNITS TO BE GIVEN AWAY FOR TESTING!

The regular cash price is $4,900. It leases at $150 a month. We are making 100 units available, eventually free of charge, as follows; Upon receipt of your check for $3,500 we will ship you a unit. You can use it as heavily as possible for 12 months. Then we will send you our questionnaire for you to complete. Upon completion, we will send you back your $3,500 and you get to keep the unit with our compliments!

The 100 units will be placed on a selective basis only to meet our needs. In cases of overlapping, we will return the check.

Fill out the coupon below and send it along with your $3,500 check.

Manufactured in the United States of America by:

STER-O-LIZER®
MANUFACTURING CORPORATION

Mailing Address: P.O. Box 27488
Salt Lake City, Utah 84127 U.S.A.
Offices: 375 West 400 North
Salt Lake City, Utah 84103 U.S.A.
Telephone: (801) 532-5600
Telex: 453048 SMC SLC

I accept your offer.

Enclosed find my check for $3,500 for one STER-O-LIZER MD-200.

Name of Doctor or Institution _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Specialty _____

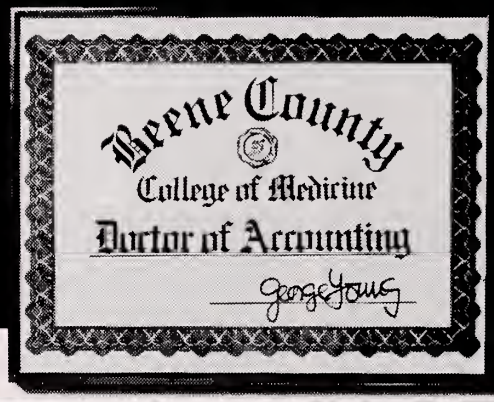
Hospital affiliation _____

Graduate of _____ Year _____

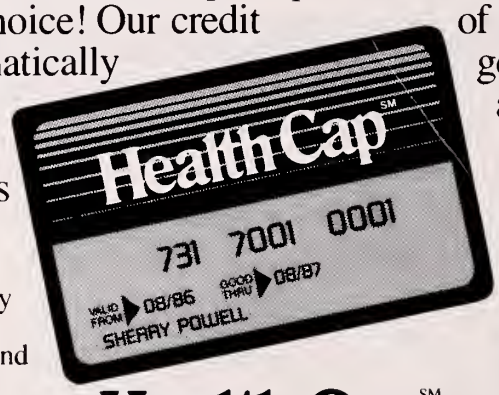
Send to:

STER-O-LIZER MANUFACTURING CORPORATION
P.O. Box 27488, Salt Lake City, Utah 84127

Your money or your life!



You can continue moonlighting as an accountant — involved in monthly billing, collections and credit problems — or spend your life as intended: practicing medicine! Health Cap's[SM] the hands-down choice! Our credit card system automatically deposits your fees in full, up front, on the day services are rendered.



And with a separate line of credit used only for health care, your patients can afford – without hardship – regular preventive treatment and elective procedures. Were all those years of study and dedication geared to chasing down accounts receivable? With Health Cap, your life is much more rewarding!

Get more information today!
Call toll-free in Florida:
1-800-282-5599;
out of state: (813) 885-6584.

C&S ® Brought to you by Health Care Assistance Corporation and C&S National Bank.

Health Cap[SM]

The credit card for your medical and financial well-being.

8316 Hanley Road, Tampa, FL 33614

10 YEARS

Thank you for your loyal support



DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

SK&F CO.


There's never been
a better time for her..
and
PREMARIN®
(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®
(Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

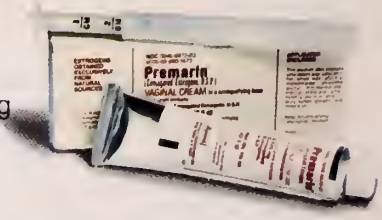
The appearance of these tablets is a trademark of Ayerst Laboratories.

For atrophic vaginitis

PREMARIN®
(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; infolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985;67:496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

© 1986 Ayerst Laboratories

Ayerst® AYERST LABORATORIES
New York, NY 10017

T6194/886

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
NOVEMBER 1986, Vol. 73, No. 11

Treatment of sickle cell disease with danazol

J. Donald Temple, M.D., William J. Harrington, M.D., Yeon S. Ahn, M.D., and Evan Rosenfeld

ABSTRACT: Five patients with sickle cell disease (S-S disease) and frequent painful crises were given danazol. All five had a dramatic decrease in crises. From these preliminary observations it appears that danazol, an attenuated androgen, may be the first agent to be of practical value in the long-term management of S-S disease.

The Authors
J. DONALD TEMPLE, M.D.
WILLIAM J. HARRINGTON, M.D.
YEON S. AHN, M.D.
EVAN ROSENFELD
Dr. Temple is Assistant Professor, and Alice and Joseph E. Brooks Faculty Scholar, Dr. Harrington is Distinguished University Professor, and Dr. Ahn, is Professor, Center for Blood Diseases, Department of Medicine, University of Miami School of Medicine, Miami; and Mr. Rosenfeld is a pre-medical student at Harvard University.

Homozygous sickle cell disease (S-S disease) afflicts approximately six per 1,000 of the American black population and is a major cause worldwide of morbidity and mortality among these peoples. It is characterized by chronic hemolytic anemia and intermittent episodes of pain due to microthrombi. Other complications include recurrent infections, renal failure, retinopathy, avascular necrosis of bones, major thromboembolic events such as strokes, and aplastic or sequestration crises. The molecular basis of S-S disease was defined in 1950,[1] yet no clinically acceptable therapy has been found.

We describe here marked symptomatic benefit in five patients given an attenuated androgen, danazol. All had been previously given clinical trials of other agents, with no benefit. Each of the patients was experiencing at least one painful crisis a month. In addition, one of the patients had had, over a six month period, daily episodes of painful priapism lasting two to three hours.

Danazol was administered in a dosage of 200 mg three times daily. The results are summarized in Table 1.

Discussion • While the molecular basis of S-S disease has been delineated, the exact pathophysiology of the vasoocclusive crises has never been adequately defined. There is little clinical correlation between the degree of hemolysis and the incidence or severity of painful crises, suggesting that the mechanisms of the two may be at least in part independent. It is known that erythrocytes which are homozygous for the S hemoglobin gene but are morphologically normal have a tendency to adhere abnormally to vascular endothelium.[2] Drugs that can alter the erythrocyte cell membrane could conceivably decrease this erythrocyte-endothelial cell affinity, thus resulting in decreased vasoocclusion.

Table 1. — Response to Danazol Therapy in Five Patients

Pt.	Painful crisis average/month Before	After	Duration of treatment Weeks	Hemoglobin mg/dl Before	After	Reticulocyte count Before	After	Bilirubin (mg/dl) Before	After	Haptoglobin (mg/dl) Before	After
1	2	0	8	8.1	8.7	12%	10%	1.1	0.7	<5	<5
2	1	0	18	8.4	10.1	16%	16%	2.0	2.3	<5	<5
3	2	0	21	9.9	10.9	21%	10%	3.0	2.6	<5	<5
4	1	0	13	8.4	8.7	12%	6%	8.4	8.0	<5	<5
5	1	0	7	8.7	9.1	36%	24%	3.4	2.8	<5	<5

Danazol, an impeded androgen, was originally approved for use in the treatment of endometriosis. It was subsequently found to be of value in refractory idiopathic thrombocytopenic purpura,[3,4] autoimmune hemolytic anemia[5] and paroxysmal nocturnal hemoglobinuria.[6,7] Recently we noted that it induces target cell formation in these and other disorders[8] although none have a hemoglobinopathy, suggesting a danazol-induced increase in the surface area to volume ratio of their erythrocytes, with some basic change in the membrane itself. This observation led us to try danazol in patients with sickle cell anemia.[9]

The effects of conventional androgens given to patients with S-S disease were studied in a few clinics several years ago.[10-15] Preparations of hormones, dosages and duration of administration varied. While improvement in hemoglobin levels were seen, discordant results were reported with respect to crises, ranging from a decrease in incidence[10,14,15] to no apparent benefit[11-13] and in men there was an increase in episodes of painful priapism.[13] No reports have appeared since 1973; the use of conventional androgens was abandoned.

Although the periods of observation in our study on the use of attenuated androgens have been short, the clinical effects have been dramatic. In addition to amelioration of crises each patient has noted improvement in sense of well-being and a substantial decrease in narcotic requirement. Especially dramatic was the prompt relief of chronic recurrent priapism in patient number five. While improvement in hematologic parameters has not been as impressive, benefit here also is apparent.

We have now initiated a trial in hereditary spherocytosis. Sufficient data are not yet available.

Danazol is a synthetic androgen chemically modified to minimize virilizing effects. We feel that it is not only better suited than conventional androgens for use in women as well as men but that in the other disorders in which we have found it to be of value its beneficial effects are not shared equally by conventional androgens. Danazol and similar attenuated androgens have few side effects and promise to provide the first practical long-term management of sickle cell disease. Insights into the mechanisms of action should lead to even further improvements.

References

1. Pauling, L.; Itano, H.A.; Singer, S.J., and Wells, I.C.: Sickle Cell Anemia, a Molecular Disease. Science 110:543, 1949; J. Biol. Chem. 1878:221, 1950.
2. Hebbel, R.P.; Yamada, O.; Moldow, C.F.; Jacob, H.S.; White, J.S., and Eaton, J.W.: Abnormal Adherence for Microvascular Occlusion in Sickle Cell Disease, J. Clin. Invest. 65:154-160, 1980.
3. Ahn, Y.S.; Harington, W.J.; Simon, S.R.; Mylvaganam, R.; Pall, L.M., and So, A.G.: Danazol for the Treatment of Idiopathic Thrombocytopenic Purpura, NEJM 308:1396-1399, 1980.
4. Ahn, Y.S.; Mylvaganam, R.; Garcia, R.O.; Kim, C.I.; Palow, D., and Harrington, W.J.: Low Dose Danazol Therapy in Idiopathic Thrombocytopenic Purpura, submitted to Ann. Int. Med., 1986.
5. Ahn, Y.S.; Harrington, W.J.; Ayub, J., Mylvaganam, R., and Pall, L.M.: Danazol Therapy for Autoimmune Hemolytic Anemia, Ann. Int. Med. 102:298-301, 1984.
6. Harrington, W.J.; Ahn, Y.S.; Cohen, J.J.; Ayub, J., and Pall, L.M.: Treatment of Paroxysmal Nocturnal Hemoglobinuria with Danazol, presented at the Twentieth Congress of the International Society of Hematology, Buenos Aires, Argentina, September 1984 (Abstract).
7. Harrington, W.J.; Ahn, Y.S.; Cohen, J.J.; Ayub, J., and Pall, L.M.: Treatment of Paroxysmal Nocturnal Hemoglobinuria with Danazol, presented at the Annual Meeting of the American Society of Hematology, December, 1984, Blood 64(5):253a, 1984.
8. Fernandez, L.F.; Ahn, Y.S.; Mylvaganam, R.; Kim, C.I.; Slackman, R., and Harrington, W.J.: Decreased Osmotic Fragility and Target Cell Formation Associated with Danazol Therapy, Blood 62(Suppl), 1986. Absatract submitted for presentation at the Annual Meeting of the American Society of Hematology, San Francisco, December, 1986.
9. Temple, J.D.; Harrington, W.J., and Rosenfeld, E.: Danazol Decreases the Incidence of Painful Vasoocclusive Crises in Sickle Cell Anemia, Blood 62(Suppl), 1986. Abstract submitted for presentation at the Annual Meeting of the American Society of Hematology, San Francisco, December, 1986.
10. Isaacs, W.A. and Hayhoe, F.G.J.: Steroid Hormones in Sickle-Cell Disease, Nature 215:1139-1142, 1967.
11. Mentzer, W.C.; August, C.S., and Nathan, D.G.: The Effects of Androgen Administration in Sickle Cell Anemia, Pediat. Res. 3:378, 1969.
12. Raper, A.B.; Black, A.J., and Huntsman, R.G.: Sickling and Steroid Hormones, Trans. Royal Soc. Trop. Med. Hyg. 64(2):293-295, 1970.
13. Lundh, B., and Gardner, F.H.: The Haematological Response to Androgens in Sickle Cell Anaemia, Scand. J. Haemat. 7:389-397, 1970.
14. Isaacs, W.A.; Effiong, C.E., and Ayeni, O.: Steroid Treatment in the Prevention of Painful Episodes in Sickle-Cell Disease, Lancet pp. 570-571, March 11, 1972.
15. Adadivoh, B.K. and Isaacs, W.A.: The Effect of Megestrol Acetate on Sickling, Am. J. Med. Sci., 265(5):367-370, 1973.

Acknowledgments

Supported by the Mary Beth Weiss, Monica E. Besade, the Theodore and Bertha Reducka and the Friends for Life Research Funds.

- Dr. Temple, University of Miami School of Medicine, Center for Blood Diseases, 1475 N.W. 12th Avenue, P. O. Box 016760, Miami 33136.

Cardiac transplantation: the first year's experience at the University of Florida — Shands Hospital

Michael J. Carmichael, M.D., Daniel R. Salomon, M.D., and L. Anne Sadler, R.N., B.S.N.

ABSTRACT: The University of Florida-Shands Hospital Cardiac Transplantation Program became operational on April 1, 1985. As of June 1986 the program has been referred 60 patients for consideration as cardiac transplant candidates. Forty two were admitted for a complete pretransplant evaluation with 20 patients accepted for cardiac transplantation. Eleven patients were transplanted with nine survivors from 55 days to 10 months after transplant.

Infection and rejection are the most common complications experienced posttransplant. The incidence of life-threatening infections within the University of Florida population is significantly lower than the national average. There have been no deaths secondary to infection. The frequency of interstitial myocardial rejection requiring therapy is approximately one episode per patient with no fatalities. Two patients expired secondary to acute vascular rejection.

In conclusion, the University of Florida-Shands Hospital Cardiac Transplantation Program has become established as a regional transplant center with survival statistics equal to the national average. Nine individuals have returned to productive lives with minimal complications.

The Authors
MICHAEL J. CARMICHAEL, M.D.
DANIEL R. SALOMON, M.D.
L. ANNE SADLER, R.N., B.S.N.
Dr. Carmichael is Director of the Cardiac Transplantation Program, Dr. Salomon is the Transplantation Immunologist, Division of Renal Medicine, Hypertension, and Transplantation, and Ms. Sadler is Cardiac Transplantation Coordinator, University of Florida College of Medicine, Shands Hospital, Gainesville.

Cardiac transplantation has evolved from the realm of an experimental to a therapeutic procedure since the first human heart transplant in 1967.[1] There has been a resurgence of interest in heart transplantation since 1982 due to significant advances in four areas: 1) immunosuppression; 2) patient selection; 3) complication management; 4) myocardial preservation techniques.

Approximately 1,000 cardiac transplants were performed in 1985, with current statistics indicating an 80% one year survival, 75% two year survival, and greater than 60% five year survival.[2] The University of Florida-Shands Hospital Cardiac Transplantation Program became operational on April 1, 1985, and the first transplant was performed on August 20, 1985.

The development of the program was motivated by a clear need for a cardiac transplant center in our geographic region and as a natural extension of the well established kidney and bone marrow transplantation programs. The procurement program at the University of Florida is one of the most active in the Southeast and well versed in multiorgan procurement.

Methods • Referrals: As of June 1986, the program has been referred 60 patients for consideration as potential cardiac transplant recipients (Table 1). Table 2 depicts the basic screening criteria used by our program to designate those patients suitable for further evaluation. Eighteen of the 60 referred were excluded; five patients could not meet the minimum financial requirement, two patients expired, six patients had fixed elevated pulmonary pressures or other medical contraindications and five patients were not processed following the initial contact. We have primarily serviced the citizens of this state (Figure 1). Potential candidates have been predominately male (54/60) and all have been New York Heart

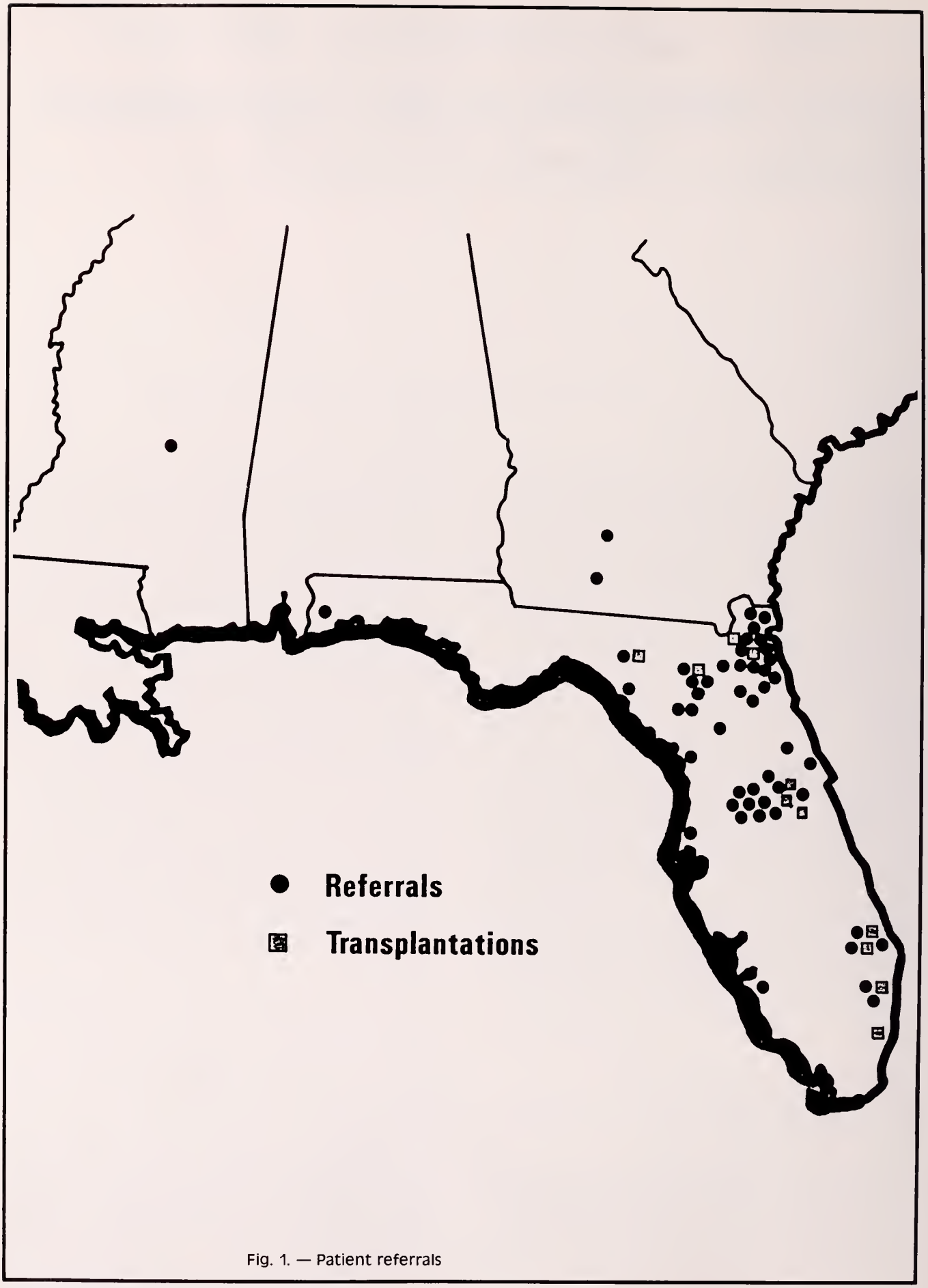


Fig. 1. — Patient referrals

Table 1. — Referrals 4/85-6/86

Referrals	
Total	60
Male	54
Female	6
Etiology	
Ischemic	25
Idiopathic	32
Rheumatic	1
Congenital	2
Age (Years)	
Range	1.5-60
Mean	42
Outcome	
Accepted for transplant	20
Expired waiting	2

Association (NYHA) class III or IV. The etiology of the primary cardiac disease was distributed as follows: idiopathic cardiomyopathy, 32; ischemic cardiomyopathy, 25; rheumatic cardiomyopathy, 1; and congenital heart disease, 2.

Evaluation: Forty-two patients were admitted to undergo a careful surgical and medical evaluation (Table 3). In addition to the transplantation surgery and medicine teams, these patients were evaluated by nursing, clinical psychology, dentistry, social work, and pastoral care services before presentation to the Medical Review Board for consideration as candidates.[3] Of the 42 patients evaluated for transplantation, 20 have been accepted and listed on the two national computer systems, the National Association of Transplant Coordinators (NATCO) and the United Network for Organ Sharing (UNOS), to await a suitable donor. A numerical priority status (Table 4) has been established to permit these computer systems to list potential candidates as a function of their relative need for transplantation.

Results • Transplant Experience: Eleven patients have been transplanted since August, 1985 (Table 5). Two patients expired prior to transplantation from complications directly related to their end stage heart

Table 2. — Recipient Contraindications

1. Age greater than 55 years
2. Fixed elevated pulmonary vascular resistance
3. Active infection
4. Recent pulmonary infarction
5. Marked obesity
6. Severe peripheral vascular disease
7. Psychosocial abnormalities
8. Inadequate financial support
9. Other organ disease

Table 3. — Pretransplant Evaluation

1. Cardiac studies
2. Pulmonary functions
3. Renal function studies
4. Abdominal Ultrasound
5. Paranasal sinus films
6. Hematologic studies
7. Viral studies
8. Tissue typing
9. Upper and lower GI
10. Clinical psychology
11. Nutritional consult
12. Dentistry consult
13. Pastoral care consult
14. Social work consult

disease. Seven patients, all at priority status 3, remained on the computer lists awaiting a suitable donor at the end of the first year.

At the time of transplantation, four of the eleven patients were in the coronary care unit on vasoactive drug infusions, two were intubated, and one required intraaortic balloon pump assistance in addition to maximal medical support. Immunosuppressive therapy includes oral cyclosporine (15 mgm/kg loading and 10 mgm/kg/d maintenance) and steroids (Solumedrol 1 gm at transplant, the Prednisone 100 mgm/d tapered as indicated clinically). Cyclosporine levels have been measured biweekly while hospitalized and maintained between 900-1500 ng/ml as measured by the whole blood RIA method. Of the eleven transplanted patients, there are nine survivors at 55 days to 10 months after transplantation.

Morbidity: Within the transplant literature, infection and rejection are the primary complications.[4,5] Cyclosporine has also been associated with hypertension, renal toxicity, and even renal failure.[6,7,8] Infectious complications have been minimal in the University of Florida's experience (Table 6). There has been one mild clinical cytomegalovirus infection, one herpes varicella infection, two localized herpes simplex infections, and several cases of oropharyngeal candidiasis. Bacterial infections have been limited to two bladder infections and two superficial wound infections.

Non-infectious surgical complications included two patients requiring reoperation for persistent mediastinal serous drainage on days 4 and 6 respectively. One patient required a transurethral resection of his prostate two weeks after transplantation.

Table 4. — Computer Priority Classification

Status	Clinical Equivalent
3	Stable at home
2	Stable in hospital
1	Unstable in hospital, vasoactive infusions
9	Unstable, intensive care unit, vasoactive infusions, intraaortic balloon pump or total artificial heart

Table 5. — Transplantations

Date of TX	Patient/Age/DX	Pretransplant NYHA Class	Pretransplant Priority Status	Current NYHA Class
8/20/85	SS, 34 yr., idiopathic	III	3	I
9/25/85	LB, 48 yr., idiopathic	IV	9	Expired*
10/9/85	LM, 52 yr., idiopathic	IV	1	I
11/13/85	WH, 19 yr., idiopathic	IV	9	I
2/5/86	JK_1, 46 yr., ischemic	IV	2	I
2/15/86	HC, 46 yr., ischemic	IV	9**	I
2/24/86	RM, 52 yr., idiopathic	III	2	I
3/19/86	MH, 28 yr., ischemic	III	3	I
4/29/86	JK_2, 59 yr., rheumatic	IV	1	I
5/6/86	FS, 56 yr., ischemic	III	3	I
5/28/86	LV, 45 yr., ischemic	III	3	Expired+

*LB died at 28 days of acute vascular rejection
+LV died at 10 days of acute vascular rejection
** on intra aortic balloon pump

All of the patients have developed systemic hypertension requiring therapy in the first week post-transplantation. Angiotensin converting enzyme inhibitors have been very effective in management of the hypertension. Early renal dysfunction, measured by serum creatinine increase, has been negligible. All of the recipients have demonstrated improved renal function in the two weeks after surgery as evidenced by a decreased serum creatinine and spontaneous diuresis. Nonetheless, whole blood cyclosporine levels have been maintained in the 900-1500 ng/ml range during the first three weeks following transplantation, a level greater than the threshold for cyclosporine nephrotoxicity in our renal transplant recipients (i.e., 500-700 ng/ml). We have noted modest increases in serum creatinine by three to four months that are clearly cyclosporine related and have been reversible with appropriate adjustments in dose. Each patient has described symptoms of cyclosporine neurotoxicity including tremor, anxiety, paresthesias, and altered mental alertness. Significant hepatotoxicity has not been observed.

Table 6. — Morbidity

Infectious Complications	
Bacterial	
Urinary tract	2
Superficial wound	2
Viral	
Cytomegalovirus	1
Herpes varicella	1
Herpes simplex	2
Fungal	
Oral candidiasis	4
Medical Complications	
Nephrotoxicity (Creatinine > 2.0mgm/dl)	0
Hypertension	11
Neurotoxicity	
Seizures	0
Tremors, etc.	11
Hepatoxicity	0

Rejection is diagnosed by histopathologic evaluation of serial endomyocardial biopsies. Our experience with cardiac transplant rejection is depicted in Table 7. Mild rejection (Grade I, perivascular aggregates of mononuclear cells) is considered the normal immune response and not treated. Moderate rejection (Grade II, perivascular aggregates of mononuclear cells with extension into the interstitium and myocyte necrosis) is treated by a three to four day course of oral or intravenous steroids, 500-3000 mgm total or an increase in oral cyclosporine dosage. Severe rejection (Grade III, myocyte necrosis, hemorrhage, edema and polymorphonuclear cell infiltration) is treated by a three day course of intravenous steroids, 3000 mgm total. A repeat endomyocardial biopsy is obtained in four days after completion of the rejection therapy. Analysis of our data demonstrates an average of one episode of rejection requiring therapy per recipient (Table 7).

Mortality: There were two fatal rejections on days

Table 7. — Rejections

Total Rejection Episodes	
Grade I	15
Grade II	11
Grade III	0

Episodes Requiring Therapy*
0 Episodes/4 Patients
11 Episodes/7 Patients

*A total of 11 rejection episodes required therapy in the 11 patients transplanted (incidence = 1 episode/patient).

ten and 28. Clinically, these were characterized by the sudden onset of profound cardiac failure. Cardiac ultrasound was performed in one patient (LB) and revealed severe generalized hypokinesis. These findings were confirmed by left heart catheterization, which also demonstrated diffuse coronary artery narrowing. Histologic studies of both transplanted hearts at the time of autopsy revealed cell-mediated vascular rejection represented by coronary vasculitis and arteriolar fibrin thrombi with obliteration of the coronary circulation. Biopsies obtained two days prior to expiration were evaluated as Grade O and Grade I rejection. Most impressive was the rapidity of their vascular collapse with death occurring less than 24 hours from the onset of symptoms.

Rehabilitation: The criteria for selection of cardiac transplant recipients limits those accepted to individuals who are severely limited in functional activity. The majority are unemployed, most are unable to function as a marital partner, and their illness is the major focus of their lives. After successful transplantation, the quality of their lives is significantly improved (Table 8). Objective evidence in improved lifestyle can be found in a return to work, enhanced self-image, active leisure activities, and in the improvement of interpersonal relations. Conflicts within the family as the recipient reestablishes himself are not uncommon but have resolved with appropriate counseling and support. The most frequent comment heard from the recipients is that they are now able to plan for their future. All state they feel physically stronger, have better endurance, and most feel they appear younger than their chronologic age.

Table 8. — Rehabilitation (n=9)

	Pretransplant	Posttransplant
NYHA Class		
I	0	9
II	0	0
III	4	0
IV	5	0
Employment		
Full-time	1	4
Part-time	0	2
Unemployed	8	3
Activity		
Full activity	0	9
Limited activity	1	0
Housebound	4	0
Hospitalized	4	0
Sexual function		
Active	2	6
Inactive	7	3

Discussion • Cardiac transplantation is a viable therapeutic modality for the treatment of end stage heart disease. Our experience reveals a predominance of male patient referrals which raises interesting questions about the incidence of cardiac failure in the female population. Though ischemic coronary artery disease is more common in males, we are not aware of previous reports that idiopathic cardiomyopathy has a predilection for males. Alternatively, women may not be diagnosed with heart failure or may not be referred for transplantation evaluation. It is also possible that some male patients with silent ischemic disease may be misdiagnosed as idiopathic cardiomyopathy, though coronary angiography has been performed on all our evaluated patients. Therefore, we believe that there is a real correlation between males and idiopathic cardiomyopathy.

The minimal incidence of postoperative infectious complications is a function of intensive postsurgical monitoring. We have used the endomyocardial biopsy to limit high dose pulse steroid therapy to only those patients with active rejection. Cyclosporine levels have been kept in the high therapeutic ranges and renal toxicity has been avoided by careful fluid and hypertension management posttransplantation.

Hypertension in cardiac transplantation is a well recognized problem though the etiology remains unclear.[9] Cyclosporine may cause hypertension via effects on the renin-angiotensin system. However, alterations in circulating catecholamines, steroid-related fluid shifts and abnormalities of vascular tone which persist from the state of heart failure preceeding transplantation have all been postulated. In any case, our success using angiotensin converting enzyme inhibitors demonstrates that posttransplant hypertension can be managed with a single drug.

The acute coronary vascular rejection which accounted for the two patient deaths is a poorly understood phenomenon in cardiac transplantation. By analogy to our experience with renal transplantation, vascular rejection may be an important problem. Accelerated coronary atherosclerosis, which has been reported by some centers as early as one year, may reflect chronic endothelial vascular damage mediated

by vascular rejection. Unfortunately, the endomyocardial biopsy is limited to the diagnosis of interstitial cardiac rejection.

In conclusion, the first year has established the University of Florida-Shands Hospital as an active cardiac transplant center. The patient survival statistics equal the national average and the infection and rejection rates are considerably less than the national experience. Of more importance, nine individuals have returned to their families and to active, productive lives with minimal complications.

Acknowledgments

The authors wish to recognize the consistent support of the University of Florida, College of Medicine and Shands Hospital without which the program could not have been successful.

Addendum

As of November 1, 1986, 18 transplants have been performed on 17 patients with 15 survivors from one day to 15 months after transplant; age 3.5 to 59 years.

References

1. Barnard, C.N.: A Human Cardiac Transplant: An Interim Report of a Successful Operation Performed at Groote Schuur Hospital Cape Town, So. Afr. Med. J., 41:1271-1274, 1967.
2. Kaye, M.P.: The International Heart Transplantation Registry — 1984 Report, Heart Transpl., 4:290-292, 1985.
3. Conti, C.R.; Salomon, D.R., and Carmichael, M.J.: Cardiac Transplantation, J. Fla. Med. Assoc., 73:111-113, 1985.
4. Pennock, J.L.; Oyer, P.E.; Reitz, B.A., et al: Cardiac Transplantation in Perspective for the Future: Survival, Complications, Rehabilitation, and Cost, J. Thorac. Cardiovasc. Surg., 83:168-177, 1982.
5. Levett, J.M. and Karp, R.B.: Heart Transplantation, Surg. Clin. No. Amer., 65:613-635, 1985.
6. Myers, B.D.; Ross, J.; Newton, L., et al: Cyclosporine-Associated Chronic Nephropathy, N.E.J.M., 311:699-705, 1984.
7. Goldman, M.H.; Barnhart, G.; Mohanakumar, T., et al: Cyclosporine in Cardiac Transplantation, Surg. Clin. No. Amer., 65:637-659, 1985.
8. Rottembourg, J.; Mattei, M.F.; Cabrol, A., et al: Renal Function and Blood Pressure in Heart Transplant Recipients Treated with Cyclosporine, Heart Transpl., 4:404-408, 1985.
9. Lake, K.D.: Post-Cardiac Transplant Hypertension,. Hosp. Ther., Sept. 1986, pp. 36-43.

- Dr. Carmichael, University of Florida College of Medicine, Box J-286, JHMHC, Gainesville 32610.

The single-unit transfusion

Ronald E. Domen, M.D.

ABSTRACT: Review and scrutiny of single-unit transfusions have been questioned; however, there is no recent, objective study of the single-unit transfusion. Therefore, the charts of 50 patients who received 51 single-unit transfusions over a 14-month period during 1984 and 1985 were retrospectively analyzed. In 38% the postoperative hemoglobin concentration increased by 0.88 ± 0.58 g/dl (mean ± SD). The estimated blood loss (EBL) during surgery in this group was 515 ± 252 ml. The remaining patients had a decrease in hemoglobin of 1.26 ± 0.84 g/dl with an EBL of 601 ± 261 ml. There was no statistically significant difference between these two groups when changes in hemoglobin or EBL were compared ($p > 0.2$). The EBL in 45.1% was less than 500 ml. In only three patients was specific notation made as to why the transfusion was given. Further evaluation demonstrated that single-unit transfusions were probably indicated in approximately 13.7% of the cases, questionable in 62.8%, and probably not indicated in 23.5%.

The Author
RONALD E. DOMEN, M.D.
Dr. Domen is Assistant Professor, Departments of Pathology and Laboratory Medicine, and Internal Medicine, University of South Florida College of Medicine; and Chief, Blood Bank and Hematology Laboratories, James A. Haley Veterans Administration Hospital, Tampa.

A recent report on transfusion practices condemns the scrutiny of single-unit transfusions and states that they often reflect appropriate use of blood rather than misuse.[1] While it is true that the single-unit transfusion is only one small component of the total transfusion service there is no recent literature examining this issue.[2] Indeed, the most recent study on the single-unit transfusion was reported in 1969 and classified 59% of them as questionable or unnecessary.[3] With this in mind and in view of the fact that hospital transfusion practices are increasingly being scrutinized and evaluated by regulatory and accreditation agencies, the single-unit transfusion at one institution was reevaluated in light of present-day transfusion practices.

Materials and methods • We studied the charts of 50 patients who received single-unit transfusions over a 14-month period during 1984 and 1985. Consecutive patients for whom charts were readily available were evaluated. The data and parameters extracted from the charts included: age, sex, diagnosis or reason for surgery, reason for blood transfusion, estimated blood loss (EBL) during surgery, and pre- and posttransfusion hemoglobin and hematocrit values. The EBL during surgery was sought in the anesthesia record, postoperative progress note, and dictated operative report. If discrepancies in the EBL were found, an average value was utilized. "Minimal" and "moderate" blood loss was each reported in one patient and interpreted as 100 ml and 500 ml respectively. Blood loss estimates were visual and not objective measurements. Also examined were clinical impressions as to why blood was transfused, any adverse reactions to red cell transfusion, and any complications occurring during surgery. Transfusions given to patients with preoperative hemoglobin of

less than 10.0 g/dl or evidence of acute blood loss resulting in signs of hypovolemia were judged to probably be necessary; those resulting in increased posttransfusion hemoglobin levels and without signs of hypovolemia were believed to be unnecessary, and the remainder were judged to have been given for questionable reasons.

Data analysis and comparisons were performed using linear regression and Student's t test for independent samples.

Results • In the 50 patients studied, a total of 51 single-unit transfusions were given. One patient underwent two operative procedures two weeks apart and recieved one unit of RBCs during each procedure. Only one of the 50 patients was a medical patient and the remainder were surgical patients. All patients had hemoglobin and hematocrit determinations within 24 hours following transfusion.

The distribution of pretransfusion hemoglobin values is given in Table 1. Forty one (80.4%) of the single-unit transfusions were given to patients with a pretransfusion hemoglobin level of 11.0 g/dl or higher. Seven (13.7%) of the transfusions were given to patients with pretransfusion hemoglobin of less than 10.0 g/dl. This included the nonbleeding medical patient who had pancytopenia secondary to myelofibrosis and an asymptomatic anemia of 9.1 g/dl who received one unit of RBCs just prior to discharge from the hospital. Two patients with hemoglobin of 9.8 and 9.2 g/dl were given single-unit transfusion prior to surgery in order to increase their hemoglobin. The remaining four patients with hemoglobin levels of 9.5 to 9.9 g/dl were transfused during surgery.

A total of 19 (38.0%) transfusions in 18 surgical patients resulted in an average increase in hemoglobin postoperatively of 0.88 ± 0.58 g/dl (mean ± SD; range 0.1-2.1). The average EBL during surgery for this group was 515 ± 252 ml (range 100-1050). The remaining 31 transfused surgical patients had decreased hemoglobin following transfusion averaging 1.26 ± 0.84 g/dl (range 0.2-2.5). The EBL in this group was 601 ± 261 ml (range 125-1200). There was no significant difference between these two groups when changes in hemoglobin or EBL were compared ($p > 0.2$). Also, no significant correlation was found between individual changes in hemoglobin and the EBL. The EBL in 23 (45.1%) cases was less than 500 ml.

In only one patient did the intraoperative indication for transfusion appear obvious. From the anesthesia record, this patient was transfused immediately after the start of a hypotensive episode. However, no notation was made anywhere in the chart that blood was transfused because of hypotension or hypovolemia. In the remaining surgical patients (n=48), no complications during surgery were noted and no reasons for the single-unit transfusion were given. In only two patients with preoperative hemoglobin less than 10.0 g/dl and the one medical patient were specific notations made in the charts as to why red cells were being transfused. In two patients the operative report and/or the postoperative progress note stated that no blood replacement therapy had been administered. No immediate adverse reactions to transfusion were noted in any of the 51 cases.

Table 1. — Distribution of Pretransfusion Hemoglobin Levels

Hemoglobin Level (g/dl)	Number patients
9.0-9.9	7
10.0-10.9	3
11.0-11.9	2
12.0-12.9	6
13.0-13.9	11
14.0-14.9	11
15.0-15.9	5
16.0-16.9	6

Discussion • The majority of single-unit transfusions were given in the operating room. The 23.5% of transfusions which resulted in increased hemoglobin levels (excluding those with hemoglobin less than 10.0 g/dl) were probably unnecessary, whereas the seven (13.7%) with pretransfusion hemoglobin less than 10.0 g/dl could be argued as being necessary. This means that 62.8% of the single-unit transfusions in this study were given for questionable indications. Also, not one of these questionable cases had documentation in the chart (other than EBL) as to why the transfusion was given. These results also show that changes in hemoglobin have no correlation with the EBL as performed in our hospital.

No immediate adverse reactions to transfusion were noted, but delayed reactions (e.g., alloantibody formation and posttransfusion hepatitis) were not evaluated in this study. The risk of developing non-A, non-B posttransfusion hepatitis from a single-unit transfusion is approximately 1.23%.[4] Alloantibody formation following a single-unit transfusion with ABO and Rh type-specific red cells is probably less than 1%.[5]

In 1960 Morton published a study on single-unit transfusions in surgical patients.[6] He believed a one unit transfusion was conservative if more than one unit might have been given, reasonable if the vital signs were not stable under anesthesia with borderline preoperative hematocrit levels, questionable if there was some suggestion of hypovolemia but transfusion might have been withheld, and unnecessary when there was no valid suggestion of hypovolemia or circulatory instability.[6] He determined that 38% of single-unit transfusions were given for questionable reasons and 34% were unnecessary. In a subsequent study several years later, and using the same criteria, Morton found that 29% were questionable and 30% were unnecessary.[3]

Another study in 1962 by King and Senhauser reached different conclusions.[7] They did not examine EBL, hemoglobin levels, or other objective criteria in their chart review. However, they concluded that many of their patients underwent serious surgical procedures that usually require more than one unit of blood and rather than criticize single-unit transfusions we ought to commend the surgeons for using so little blood. Using more objective criteria, such as a hemoglobin less than 10 g/dl, blood loss with changes in vital signs, and an EBL of greater than 500 ml Diethrich[8] found that between 60-70% of single-unit transfusions were not indicated. Likewise, Reece and Beckett,[9] using the criteria of Morton,[6] found that 67% of single-unit transfusions were given for questionable or unnecessary indications. Finally, in 1966, Crispen found that 65% of single-unit transfusions were probably or definitely not indicated.[10] In addition, he found that 43.1% of single-unit transfusions actually resulted in increased hemoglobin and hematocrit values and that 71.8% were given to patients with hemoglobin of 11 g/dl or greater.[10]

The retrospective evaluation of blood use, particularly when it involves intraoperative transfusion, is often a matter of opinion which leads to considerable debate. However, the prevailing attitude that single-unit transfusions are justified and should not be scrutinized[1,11,12] is not supported by our study or by most of the published studies. In fact, it would seem that the small change in hemoglobin level achieved in the adult receiving a single-unit of RBCs rarely justifies the definite risk involved. If the surgeon and/or anesthesiologist are to be commended for stopping at only one unit of blood then adequate and proper documentation should be made as to why red cells are being transfused. Admittedly, the single-unit transfusion is only a small component of the whole transfusion service and should not be used in lieu of other methods of blood utilization review. Inappropriate single-unit transfusions, however, may just be a reflection of other improper transfusion practices. Each institution should set standards for blood utilization, and review of its single-unit transfusions may be a good starting point.

Acknowledgments

The author would like to thank Janet K. Domen MT(ASCP), and Ana Calero, MT, for reviewing the manuscript and providing helpful comments.

References

1. Grindon, A.J.; Tomasulo, P.A.; Bergin, J.J.; Klein, H.G.; Miller, J.D., and Mintz, P.D. Hospital Transfusion Committee: Guidelines for Improving Practice, JAMA 253:540-543, 1985.
2. Heustis, D.W.; Bove, J.R., and Busch, S.: Practical Blood Transfusion, 3rd ed., Boston, Little, Brown, 1981, pp. 222.
3. Morton, J.H.: Surgical Transfusion Practices, 1967, Surgery 65:407-416, 1969.
4. Conrad, M.E.; Knodell, R.G.; Bradley Jr., E.L.; Flannery, E.P., and Ginsberg, A.L. Risk Factors in Transmission of Non-A, Non-B Posttransfusion Hepatitis: Role of Hepatitis B Antibody in Donor Blood, Transfusion 17:579-585, 1977.
5. Mollison, P.L.: Blood Transfusion in Clinical Medicine, 7th ed., Boston, Blackwell Scientific Publications, 1983, pp. 236-237.
6. Morton, J.H.: Evaluation of Blood Transfusion Practices on a Surgical Service, New England J. Med., 263:1285-1287, 1960.
7. King, J.W. and Senhauser, D.A.: Trends in Blood Utilization, Transfusion 2:344-348, 1962.
8. Diethrich, E.B.: Evaluation of Blood Transfusion Therapy, Transfusion 5:82-88, 1965.
9. Reece, R.L. and Beckett, R.S.: Epidemiology of Single-Unit Transfusion, JAMA 195:113-118, 1966.
10. Crispen, J.F.: Single-Unit Transfusion: Continuing Problem, Pa. Med. J. 69:44-48, 1966.
11. Mintz, P.D.: Single-Unit Blood Transfusions (letter), New England J. Med. 309:614, 1983.
12. Friedman, B.A. Burns, T.L.; Schork, M.A., and Kalton, G.: Description and Analysis of Current Blood Transfusion Practices in United States with Applications for Hospital Transfusion Committee, Clin. Lab. Ann. 1:147-169, 1982.

- Dr. Domen, Chief, Blood Bank and Hematology Laboratories (113), Veterans Administration Hospital, 13000 North 30th Street, Tampa 33612.

For Your Benefit...

From The Florida Medical Association Sponsored Insurance Plans.

Diagnosis: FMA Members and Employees, Need Dependable, Comprehensive Coverage In Medical Care, Life, Disability and Dental At Economical Group Rates

Treatment: Enroll NOW in Your Florida Medical Association Sponsored Insurance Plans

Prognosis: Excellent. FMA-SIP Offers Flexibility, Convenience, Efficiency In An Insurance Package Designed Exclusively For You.

• Major Medical • Dental
• Short-Term Disability
• Life And AD&D

☐ Developed from your specifications by your Association and offered exclusively to FMA members and their employees. Dependents coverage available for Medical and Dental benefits.

☐ Marketing by Florida's leading insurance consultant, Brown and Brown, Inc., for further information contact us at the toll free number below.

☐ Underwritten by one of America's largest and strongest insurance companies, Mutual of Omaha.

☐ Administered by FLAMEDCO, Inc., highly regarded for rapid, efficient claims and enrollment administration and a wholly owned subsidiary of your own Florida Medical Association.

FMA/SIP Offers You Great Flexibility. You Choose The Coverage You Need:

Major Medical, Million-dollar protection with your choice of $200 or $500 annual deductibles and the new Medical Deluxe Plan.

Dental, Benefits of up to $1,000 per person each year. Optional if you elect Major Medical.

Life, Group term life insurance coverage for you and your employees. You select coverage level from $10,000 to $100,000.

Disability, If you elect life insurance, you also may choose from among four short-term disability options, either 13-week or 26-week coverage with or without maternity.

Call Toll-Free
1-800-624-3953 *For Details*

P.O. Box 4938
Jacksonville, Florida 32201



Florida Medical Association, Inc.
Sponsored Insurance Programs

Victoria Ann-Lewis moves so gracefully on stage the audience doesn't even know she has polio.



PHOTO: HELEN NESTOR

Victoria Ann-Lewis has achieved international recognition as a television and stage performer. She conducts workshops in acting and movement for women with disabilities. In 1983 she won the California Governor's Committee on Employment of the Handicapped Individual Achievement Award for the television musical, *Tell Them I'm A Mermaid*, which she developed and starred in.

Believe in them. Break the barriers.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, WASHINGTON D.C. 20210

PRODUCED BY THE SCHOOL OF VISUAL ARTS PRESS, LTD.



What he's inherited is *Duchenne*, the most common and devastating form of muscular dystrophy.

Like all twelve forms of MD, Duchenne can be passed from parent to child by a defective gene. Parents can "carry" the gene, but be unaffected by the disease.

The Muscular Dystrophy Association is striving to find the gene responsible for Duchenne. Because not only is that the first big step in finding a cure, it's also a 100% certain way to identify parents at risk.

MDA is pouring all possible resources into the fight against Duchenne. Because although it's said that you can't take it with you, there are some things no one wants to leave behind.

MDA

Muscular Dystrophy Association, Jerry Lewis, National Chairman

SPECIAL ARTICLE

Barriers to effective medical discipline and some possible solutions

Richard J. Feinstein, M.D.

An important aspect of any discussion of medical malpractice and professional liability insurance is the relationship, if any, between incompetent doctors, medical discipline and the incidence of malpractice. Two articles published within the past 24 months[1,2] showed that most medical boards disciplined relatively few physicians in the years reported, while a few boards disciplined none. Much attention has been given to the number of physicians disciplined for each 1,000 practicing, and some discussion is necessary to understand what these numbers mean.

I believe that there are at least three factors which influence the number of disciplinary actions reported by licensing boards. The first is the large variety of definitions used by state boards for the disciplinary actions imposed on medical licensees. These vary and include: private or public reprimand; fine or payment of costs; restriction of practice or prescribing powers; period of probation with or without other restrictions; educational requirements, such as demand for extra training or passage of a special exam, usually component two of the FLEX; period of license suspension; and the ultimate board sanction, revocation of a medical license.

Some states enter into informal agreements with physicians who have been charged with statutory violations in which the physician agrees to alter his illegal behavior or practice in return for a decision by the board to not impose formal or public discipline. Sometimes these are not considered to be disciplinary actions and they may represent an attempt to carry out board-imposed sanctions without the perception that such a sanction has really occurred. It is my opinion that such a private arrangement between a public agency, a state board of medicine, and a physician who is believed to have violated a state regulation, does a great disservice to the citizens and the medical profession by inspiring those who still imagine, as George Bernard Shaw did, that medicine is more a conspiracy than a profession. It is interesting that while most states now clamor for national recognition of their ability to discipline physicians and demonstrate better disciplinary records than other states, some boards would still continue such archaic practices as disciplining physicians in secrecy and handing out private reprimands.

Discrepancy in collecting and reporting data to the Federation of State Medical Board's (FSMB) Disciplinary Data Bank is a second possible reason for variations in the number of disciplinary actions reported by licensing boards each year. We should have no sympathy, I believe, for states who fare poorly on the FSMB's annual report of disciplinary actions because they failed to report their data in a timely and appropriate manner. Not only is the data important for evaluation and study by the FSMB and others interested in the regulatory process, but it is absolutely vital for all disciplinary boards to share information about incompetent physicians with all other states so that a national effort will succeed in dealing with those physicians who attempt to flee disciplinary problems by moving their practice to other states. If private efforts through the FSMB are not successful, there are those in the Congress who wish to assume control of physician licensing and discipline to prevent state jumping by incompetent doctors.

The Author
RICHARD J. FEINSTEIN, M.D.
Dr. Feinstein is Clinical Associate Professor of the Department of Dermatology, University of Miami School of Medicine, Miami.

The quest to be near the top on the FSMB's annual list of physician discipline must be tempered by honest reporting and a standardization of the definitions and procedures used in collecting disciplinary data. We should not ignore the fact, however, that a list of the number of annual disciplinary actions is merely one way to evaluate a medical board's effectiveness. Bryant Galusha, M.D., Executive Vice President of the FSMB,[3] believes that the total number of annual board reviews may be a more accurate measure of medical board activity than the number of disciplinary actions. This could include the number of complaints filed against physicians; the number of files reviewed by the probable cause panel; the number of physicians charged with an administrative complaint; and the number disciplined. This would give a more accurate measure of the time and energy expended by a state board on behalf of the citizens in pursuit of professional regulation. A board may investigate and prosecute a large number of cases, yet discipline relatively few because of uncooperative hearing officers, inexperienced prosecutors or other factors which are outside the boards' immediate control and which would need legislative remedies to solve.

A third reason for the large variation in annual reporting by medical boards is an undeniable and objective observation that some states are better at providing services to their citizens than others. Some states have better highways, insurance regulation, public health services, and professional and occupational regulation because they have made a commitment to assist their citizens through the use of the state's power, wealth and prestige.

Legislators may fail to write effective legislation for the licensing and discipline of physicians because of ignorance of the issues or a preoccupation with other legislative tasks that are believed to be more important. Some legislators believe that every aspect of their task is political.

It is important to look at the specific reasons why some states are better at regulating the practice of medicine than others and to evaluate barriers that exist to the regulatory process. I believe there are three general barriers. The first are legislative and bureacratic barriers which may be imposed by uncooperative state governments. Legislators may fail to write effective legislation for the licensing and discipline of physicians because of ignorance of the issues or a preoccupation with other legislative tasks that are believed to be more important. Some legislators believe that every aspect of their task is political. They pay homage to the highest bidders and bow to pressure from lobbyists and campaign contributors by failing to support legislation that is required by the medical board on behalf of the regulatory process. Regulatory board members are generally biased in their zeal for effective regulation and almost all believe that the failure to enact proper legislation is detrimental to the majority of the electorate, who would support an efficient regulatory process if they had a direct political voice. It is sometimes difficult to convince legislators about the need for adequate funding, personnel, and effective legislation to ensure the efficiency of the process.

Even a state's governor may place a bureaucratic barrier in the way of effective professional regulation by using the statutory authority vested in him to appoint individuals to the board as a way to repay political favors. In some states, like Washington, the state medical association selects some board appointees. Ideally, whatever the selection mechanism involved, only the most qualified physicians and public members available in the state should be invited to serve on the state medical board.

In Florida, as in some other states, the Board of Medical Examiners is part of a larger government agency, the Department of Professional Regulation (DPR) which has legal and administrative authority over all professional and occupational boards. The Secretary of this super department, a secondary level cabinet officer in Florida who is appointed by the Governor, has great power to influence the legislative, administrative, and bureaucratic effectiveness of the board. DPR does most of the lobbying for the board, determines staffing and funding priorities, and interacts with the legislature and governor as the DPR and Board representative. The DPR secretary must work closely with the medical board to accomplish mutual goals.

A second general barrier to effective policing by state boards is the professional barrier that may be constructed, willfully or not, by the licensed physicians of the state. A barrier may be created by physicians who are unwilling to serve on the state medical board when appointed, or if they do serve, fail to give all that is required in time and effort to do the job well. Serving as a member of a medical licensing and disciplinary board is an arduous and time-consuming task that is often cause for great anxiety. This task is performed in return for very modest compensation and with little or no gratitude from others. Serving as a board member is often an effective way to retard a medical practice because of time spent away and because board service sometimes deters referrals from other physicans in the community who may look upon the disciplinary board member with some degree of suspicion.

A large number of physicians are also required to serve as consultants, expert witnesses, and to review files and participate in administrative hearings. Still

other physicians are needed to supervise doctors who have been disciplined and ordered to practice in a structured setting. The remuneration for participation in government service is not high. Occasionally medical board members are disturbed by rigid state edicts over their choice of airline or rental car company, but despite such difficulties a large number of physicians must be willing to serve on behalf of good government and as a way to demonstrate an interest in policing their profession.

All physicians must make a commitment to report other phsycians whom they know are guilty of incompetent or illegal medical practice. About half of the 65 disciplinary board members of the FSMB have legislation which requires physicians, hospitals or medical associations to report incompetent physicians, but few complaints against doctors are ever made by hospitals or other physicians.

All physicians must make a commitment to report other physicians whom they know are guilty of incompetent or illegal medical practice.

Another professional barrier to an effective medical board may be imposed by uncooperative state and county medical associations. A medical association may be hostile and criticize the state medical board for disciplining doctors in its state, many of whom may be members of the association.

Some state medical associations, including those in New Jersey, Florida and Georgia, now fund and maintain programs for impaired physicians. These private organizations have helped hundreds of addicted physicians recover from impairment to return to their medical practices and families. One key to their success is a promise of confidentiality to the impaired physician and a guarantee to shield him from discipline as long as he cooperates with the diversion and treatment plan. Officials of these programs often threaten to report uncooperative impaired physicians to the state medical board as a way to encourage compliance. While the ploy of threatening to report uncooperative addicted physicians to a strong medical board is understandable, cooperation must exist between officials of the impaired physician program and the medical board so the public can be assured that sick doctors are not harming patients.

Medical associations should encourage their state medical board to be more effective by openly lobbying themselves for better legislation and increased funding for the board. The California Medical Association requested an increase in the state licensing fee in 1974 to ensure that adequate funds would be available for effective medical discipline at the same time they were asking the legislature to enact MICRA, the malpractice reform act. It would be prudent for all physicians and medical associations who ask state legislators for malpractice relief through tort reform to also request an increase in medical license fees. The revenues obtained must specifically be allocated by the legislature to the state medical board for licensing and discipline.

Another possible barrier to effective policing comes from the legal concept of due process and the right of every American defendant to be considered innocent until proven guilty. Physicians as defendants often employ the best legal counsel available. In Florida, a defendant who elects to have a full adminstrative hearing may incur legal expenses of $30,000 or more for a skilled administrative or criminal attorney, while the state employs young attorneys who earn less than that amount as their annual salary. We must realize that some physician offenders will go undisciplined because they have the ability to employ more able counsel than the state agency that is attempting to prosecute them.

I served on the Florida Board of Medical Examiners for six and one half years and have suggestions for removing some of the barriers to effective medical discipline. Mandatory reporting laws are necessary. These statutes make it a ground for discipline for a physician to fail to report a colleague whom he believes has violated the state's practice act. Twenty-nine states have mandatory reporting laws for physicians; 45 require hospitals to report physicians who have been disciplined or who have had their privileges restricted; and 26 states require state and county medical societies to report doctor members who have been disciplined.[4] Some physicians resign from a hospital staff or a county medical association rather than face charges that could result in discipline, and such activities must be considered involuntary actions and reported to the medical board for investigation.

While mandatory reporting is in theory an excellent mechanism to learn about bad doctors from other doctors, few complaints are ever filed against physicians by other physicians, hospitals or medial associations. In Florida, less than 3% of the 6,400 complaints made against physicians in the six years from 1979-1985 were made by hospitals.[5] Hospitals may allow a physician to resign under pressure rather than actually dismiss him from the medical staff in order to forgo the unpleasant task of participating in an investigation and hearing. Similarly, physicians are reluctant to report incompetent colleagues because they prefer to avoid the anxiety of participating in the disciplinary process.

States must back up mandatory reporting laws by providing full legal immunity to physicians, hospitals, and medical associations who do cooperate, when their actions are made in good faith. Legal immunity must also be extended to hospital peer review committees whose records of disciplinary action against a colleague are now open to subpoena in Florida.

Hospital committees should not be allowed to deal with physician incompetence secretly as though the hospital was not part of a larger medical and social community. Some individuals believe that data obtained by the federally funded statewide Professional Review Organizations (PROs) should also be made available to medical boards.

Sunshine laws, such as the one that applies to all state governmental activities in Florida, are an excellent mechanism for policing the medical profession more effectively. It only perpetuates fears that physician-dominated state medical boards are part of a conspiracy of silence if they are allowed to meet in closed chambers.

Sunshine laws, such as the one that applies to all state governmental activities in Florida, are an excellent mechanism for policing the medical profession more effectively.

A medical board's probable cause panel, however, must be allowed to meet secretly, safeguarded by the presence of staff from the attorney general's office and a court reporter, to investigate charges against physician licensees. Only those complaints which represent a true violation of the medical practice act, resulting in the panel's findings of probable cause and the issuance of an administrative complaint, are reported to the public and the media. This system protects a physician from frivolous and nonmeritorious complaints, but allows public scrutiny when there is substantial reason to believe that the law was violated. Transcripts of the panel's deliberation of its own cases are available to individual physicians and their attorneys.

Some of the larger states, such as California, New York, and Illinois, have divided the state board into component parts which deal separately with licensing, discipline, and ancillary health licensees. Currently Florida has a single board with 13 members which must perform all the tasks involved in the licensing and discipline of some 39,000 physicians and allied health workers. Board members must also serve on a joint pharmacy committee for the state's negative formulary; pharmacist prescribing committee; advanced registered nurse practitioners committee; physician's assistant advisory committee; impaired physicians committee; foreign medical graduates committee; respiratory therapist committee; occupational therapist and physical therapist committee; legislative committee; and communication committee. Simply increasing the number of board members does not create more effective use of their time for professional regulation. In fact, an increased number of board members creates the need for a larger quorum and more time for discussions on each disciplinary or licensing case.

While a definite link has not been made between the incidence of malpractice and effective medical discipline, the connection is certainly possible and it is reasonable to require a medical board to review physicians who have been sued a lot. The Orlando Sentinel[5] in a week-long series on malpractice published data showing that over a ten year period from 1975 to 1985, 3% of physicians in Florida were responsible for nearly half the malpractice awards. Until the 1985 legislative session, the Florida medical board had no legal authority to review physicians who were sued for malpractice. The Malpractice Reform Act of 1985 requires the State Insurance Department to report to the medical board any licensed physician who settled or lost three or more malpractice claims for $10 thousand or more within five years.

While this legislation will create an enormous amount of extra work for the medical board and its Probable Cause Panel, which must scrutinize investigative files and court transcripts, it will go a long way toward making certain that the few physicians who are sued because of repeated negligence and gross malpractice are investigated and, if need be, disciplined by the board. Six hundred seventy-five doctors paid two or more malpractice claims each in Florida in the past decade and one can only speculate on how many of these would have been disciplined by the board under the current law.

I sincerely believe that the United States has the best medical care and best physicians in the world. Although state medical boards have existed in some states for a hundred years, I believe that professional regulation is metaphorically in its infancy because the public and the government essentially ignored the process until recently. Along with a renewed interest in consumer protection, private and public agencies have developed a concern for professional regulation and a desire to provide competent medical care for all Americans.

With the recently increased efficiency and professional management of the Federation of State Medical Boards, a central agency now exists to set goals for all state boards, especially those that have been least able or interested in performing licensing and discipline effectively. While the FSMB has no legal authority and serves at the will of its members, it does have stature and respect as the organization with the most expertise and interest in medical licensing and discipline. It should continue to prepare model guides for practice acts, disciplinary proceedings, and all the other important tasks that medical boards must perform. It must try to cajole weaker boards to improve themselves and become more efficient.

It will be ideal when the FSMB's Disciplinary Data Bank is made available to all member boards through an on-line computer so that disciplinary data can be transmitted and received instantaneously from board offices across the country. Member boards can

be requested to report their data daily or weekly for use by other states, rather than allowing mail service to delay such requests and transmissions.

One barrier to effective discipline has been the failure of mandatory reporting laws because of the difficulty that most people, including physicians, have in reporting the illegal activities of others to police or administrative authorities. An article by a senior medical student in the University of Miami School of Medicine student newspaper, *The Fovea*, described medical students who arrived for hospital rounds stoned on drugs. Others were observed falsifying medical records or the time that certain blood tests were drawn, such as blood sugars on diabetic patients. Most people, including medical students and physicians, are reluctant to report their colleagues for possible discipline, even when they may feel that it is morally the correct thing to do. Perhaps an educational process in ethics for medical students will eventually help them to understand their obligation to society and some day more physicians will be able to participate in the disciplinary process by reporting incompetent or dishonest colleagues.

One barrier to effective discipline has been the failure of mandatory reporting laws because of the difficulty that most people, including physicians, have in reporting the illegal activities of others to police or administrative authorities.

An important way to remove the legislative barrier to effective medical discipline is to teach medical board members how to talk to state legislators. Larry Dixon, State Senator and Executive Director of the Alabama Medical Board, made a presentation at the FSMB's annual meeting in May, 1986 on ways to influence legislators about medical board policies. It would behoove all medical boards and the state agencies that they are affiliated with, like DPR in Florida, to teach medical board members to deal more effectively with legislators. In certain situations, members of the state medical board are part of just a very small number of physicians in the entire state who have the knowledge and interest to affect legislation on medical licensing and discipline. Constraints created by time, distance, inadequate funding, and a lack of lobbying expertise, may inhibit them from sharing their knowledge with key members of the legislature. In Florida, DPR should devote more effort to make individual regulatory board members effective lobbyists rather than attempting to fulfill the lobbying needs of all boards by itself. DPR is the umbrella agency for one million licensees and 30 occupational groups, and there is no way it can effectively lobby for the diverse needs of all these boards and professionals, especially when the needs of some boards under DPR often runs counter to the needs of others.

A last suggestion to improve medical regulation is a need for more communication between state medical boards and the several hundred regulatory board members. Few medical board members have taken pen in hand to communicate their experiences or offer suggestions for change and few medical journals devote space to articles on this subject. As our society demands increased competence of physicians and decreased cost of health care, innovative methods must be shared to more efficiently grant medical licenses to only those physicians who deserve them, and remove or restrict licenses from those physicians who are no longer capable of practicing medicine with reasonable skill and safety. Modern medical boards have come a long way in a relatively short period of time, but much still has to be done to protect Americans from incompetent physicians.

References

1. Feinstein, R.J. The Ethics of Professional Regulation, NEJM 312:801-804, March 21, 1985.
2. Wolfe, S.M.; Bergman, H., and Silver, G.: Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform, Health Research Group Report, August 27, 1985.
3. Galusha, B.L. and Breaden, D.G.: Concentrating on the Liability Crisis: A Medical Board Perspective: Federation Bulletin, Vol. 73, No. 5, pgs. 131-140, May 1986.
4. Galusha, B.L.. Personal Communication.
5. Goudreau, R. and Beasley, A.: Medicine on Trial: The Malpractice Crisis, The Orlando (Florida) Sentinel, April 13-20, 1986.

● Dr. Feinstein, 3661 S. Miami Ave., Miami 33133.

New rules link CME to licensure renewal

Pierre J. Bouis Jr., M.D., and Robert C. Fore, Ed.D.

The general licensing provisions of Florida Statute 455.213(5) specify evidence of continuing medical education as a condition of renewal of medical license. Rules for implementing the continuing medical education requirement have been promulgated and are included in their entirety at the end of this article.

As a membership requirement, the Florida Medical Association has mandated continuing medical education since January 1, 1974 when the first three-year cycle began. Members have been required to complete a minimum of 150 hours of continuing medical education during each three year cycle including at least 60 hours of AMA Category I credit, or its equivalent (American College of Emergency Physicians Category I; American Academy of Family Physician Prescribed Credit; American College of Obstetricians and Gynecologists Cognates) and/or FMA Mandatory credit. As of February 1, 1986, FMA Mandatory credit was no longer granted, having been replaced by AMA Category I credit. The remaining 90 hours have been accepted in a wide variety of elective or Category II credits.

Physicians who have conscientiously adhered to FMA membership requirements, which basically mandate the accumulation of 20 hours of AMA Category I credit per year, will have no problem meeting the new requirement for license renewal. Therefore, with the exception of a requirement for reporting elective or Category II credits, the FMA membership requirement and the requirement for license renewal are almost identical. For example, the FMA membership requirement mandates 60 hours of AMA Category I credit over three years while requirements for license renewal specify 40 hours over two years.

The primary difference in the continuing medical education requirements focuses on reporting and content. In order to satisfy FMA membership requirements, physicians currently report their credits directly to their county medical society which verifies compliance and submits lists directly to the FMA. On the other hand, physicians seeking renewal will be asked to sign a form included on the application. The physician will not submit a list of credits to the Department of Professional Regulation when he submits his application. However, it is critically important for the individual physician to maintain evidence of credits earned as the Board of Medicine will audit at random. Physicians should, therefore, insist that their attendance is recorded at all continuing medical education programs and ask for some type of affidavit such as a certificate or receipt.

Although the FMA and the Department of Professional Regulation allow freedom of choice in continuing medical education subject matter, one exception is a five hour requirement in risk management for license renewal. The five hour requirement shall be earned on a biennial basis rather than each year. The Florida Medical Association and the Florida Physicians Insurance Company have jointly offered a five hour risk management course with AMA Category I credit certified through the Florida Medical Foundation Committee on Continuing Medical Education. Since May 31, 1986, the course has been offered six times at various locations around the state

The Authors
PIERRE J. BOUIS JR., M.D.
ROBERT C. FORE, ED.D.
Dr. Bouis is Associate Dean for CME, University of South Florida College of Medicine, and Chairman of the FMA Council on Scientific Activities, and Dr. Fore is Associate Executive Director for Programs and Administration for the FMA.

with a total attendance of 850 physicians. Information on upcoming locations and dates can be obtained from Robert W. Seligson, M.B.A., FMA Director of Medical Economics, (904) 356-1571. When deciding on whether or not to register for a course in risk management, physicians are cautioned to insist on information concerning the credit awarded and the source of the credit, i.e. is the course offered by an accredited CME sponsor such as a hospital or medical school? Extreme caution should be taken relative to programs which are primarily on video-tape. Many such courses only offer Category II credit which clearly will not satisfy the license renewal requirement.

Physicians whose licenses expire on December 31, 1987 will be the first required to adhere to the new continuing medical education rule based on credits earned since January 1, 1986. During 1987, the FMA Council on Scientific Activities will be reviewing the license renewal rule vis-a-vis the FMA membership requirement in order to determine what changes in the membership requirement may be advisable.

THE FULL TEXT OF THE PROPOSED RULE IS:

CHAPTER NO.	CHAPTER TITLE:
21M-28	Reactivation of Inactive License; License Renewal.
RULE NO.:	RULE TITLE:
21M-28.002	Continuing Education for Biennial Renewal

(1) Every physician licensed pursuant to Chapter 458, Florida Statutes, shall be required to complete 40 hours of continuing medical education courses approved by the Board in the 24 months preceding each biennial renewal period as established by the Department. At least 5 of such continuing medical education hours required for renewal shall concern risk management.

(2) For purposes of this rule, risk management means the identification, investigation, analysis, and evaluation of risks and the selection of the most advantageous method of correcting, reducing, or eliminating identifiable risks.

(3) During the license renewal period of each biennium, an application for renewal will be mailed to each licensee at the last address provided to the Board. Failure to receive any notification during this period does not relieve the licensee of the responsibility of meeting the continuing education requirements. The application for renewal shall include a form on which the licensee shall state that he has completed the required continuing education. The licensee must retain such receipts, vouchers, certificates, or other papers, such as the physician's recognition awards issued by the AMA, as may be necessary to document completion of the continuing education listed on the renewal form for a period of not less than 4 years from the date the course was taken. The Board will audit at random a number of licensees as is necessary to assure that the continuing education requirements are met.

(4) Failure to document compliance with the continuing education requirements or the furnishing of false or misleading information regarding compliance shall be grounds for disciplinary action up to and including license revocation.

(5) The continuing education requirements for renewal shall not apply to a licensee during the biennium in which he is first licensed in Florida, but shall apply to such licensee in every biennium thereafter.

(6) The following courses are approved by the Board:

(a) Organized courses approved for American Medical Association Category I Continuing Medical Education credits or accepted for the American Medical Association physician recognition award.

(b) Any postgraduate training program accredited by the Accreditation Council for Graduate Medical Education.

(c) The following specialty training: American College of Emergency Physicians, Category I; American Academy of Family Physicians prescribed credit; and American College of Obstetricians and Gynecologists cognates.

Specific Authority: 458.309, 455.213(5), F.S.
Law Implemented: 455.213(5), F.S.
History: New 9-7-86

- Dr. Fore, Associate Executive Director for Programs and Administration, FMA, 760 Riverside Ave., P.O. Box 2411, Jacksonville 32203.


Some People
Commit Child Abuse Before
Their Child Is Even Born.
According to the surgeon general, smoking by a pregnant woman may result in a child's premature birth, low birth weight and fetal injury. If that's not child abuse, then what is?
AMERICAN
CANCER
SOCIETY®

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

- —drug and disease information
- —clinical abstracts
- —administrative and medical-practice information
- —Continuing Medical Education courses
- —Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC.
P.O. BOX 2411, JACKSONVILLE, FL 32203
TELEPHONE 904/356-1571

University of Miami School of Medicine — Department of Medicine
Twenty-Second Annual Postgraduate Course

"INTERNAL MEDICINE 1987"

March 1-6, 1987

Sheraton Bal Harbour Hotel — Bar Harbour, Florida

The objective of this course, the twenty-second in its series, is to provide an annual updating of the most useful recent advances in the diagnosis and management of internal medical disorders as they are encountered by primary care physicians and practicing specialists. A synopsis and self-assessment questionnaire will be provided.

A distinguished guest faculty will present "State of the Art Lectures" and conduct panel discusions.

Guest Faculty

Robert A. Good, M.D.
Professor and Chairman
Department of Pediatrics
University of South Florida
St. Petersburg, Florida

Daniel J. McCarty, M.D.
Will and Cava Ross
Professor and Chairman
Department of Medicine
Medical College of Wisconsin
Milwaukee, Wisconsin

Kenneth M. Moser, M.D.
Professor of Medicine
University of California
San Diego, California

Robert G. Narins, M.D.
Professor of Medicine
Temple University School
of Medicine
Philadelphia, Pennsylvania

HIGHLIGHTS

SPECIAL SYMPOSIUM ON "AIDS"

An experienced faculty will discuss the latest developments of the Acquired Immunodeficiency Syndrome.

MEET THE FACULTY SESSIONS

Small group conferences in which selected topics in internal medicine will be presented, followed by open discussions.

ACCREDITATION

Supervised CME Activities 33 Hours Credit
"As an organization accredited for continuing medical education, the University of Miami School of Medicine designates this continuing medical activity as meeting the criteria for 33 credit hours in Category I of the Physician's Recognition Award of the American Medical Association."

This Program has been reviewed and is acceptable for 33 Prescribed hours by the American Academy of Family Physicians.

PICTORIAL QUIZ

Our well-established teaching method will cover all fields of internal medicine and will be available throughout the meeting.

EXHIBITS

Selected Scientific and Technical Exhibits will be on display.

VIDEOTAPE SYMPOSIUMS

A large TV screen will show selected subjects during the evenings.

HOTEL ATTRACTIONS

The Sheraton Bal Harbour is located directly on the ocean with 600 feet of private beach, an olympic-sized salt water pool and a salt water indoor pool, and across the street from the exclusive Bal Harbour Shops (Saks Fifth Avenue, Neiman-Marcus, Bonwit Teller — 100 shops in all). Tours, golf, tennis, fishing may be arranged through the hotel.

SOCIAL ATTRACTIONS

A varied program for spouses and children will be offered daily.

Registration: $500/Physician, $350/Physician in Training (a letter from Chief of Service must accompany registration)

For Registration and Information Write: J. S. Bocles, M.D., Department of Medicine (R760), University of Miami School of Medicine, P.O. Box 016760, Miami, FL 33101, (305) 547-6063.

Physicians and the challenge of politics

The 1986 Nobel Award for Economics was bequeathed upon Professor James Buchanan of George Mason University in Virginia. Dr. Buchanan developed and derived supportive data for an economic concept that he has designated as "Public Choice." This theory contends that politicians, who are responsible for the economic policies of government, are motivated and behave by concerns of self interest — such as the personal attainment of power, position, wealth and reelection. This theory clashes with the common view of current political theorists which holds that politicians respond to concerns for the general public welfare. Dr. Buchanan has punctured the idealistic bubble of our political theorists and has revealed that politicians, like most humans, behaviorally align themselves with interests that indulge their own desires.

Most of us who have aged beyond life's third decade have suspected that politicians were ruled by concerns other than the humanistic needs of society. Now that the Nobel Committee has stamped it imprimatur upon our a priori-derived suspicions it is safe to uncloset our cynicism and act upon it. If politicians truly prioritize their responses to their own needs then we need to ask, "who is looking out for the needs of physicians?" Unfortunately, no one but the doctors. Since politicians, by their decisions, control huge proportions of the economic output of any country it follows that doctors need to protect their own economic interests by immersing themselves in the political process.

Previous articles in this series on medical economics have attempted to examine the elements of power and politics from an historical perspective. Last month's article on medicine and Machiavelli pleaded for the establishment or expansion of the physician-politician class of individuals. I would like to develop this theme more thoroughly. Since tort reform and a huge revision of the state's indigent care programs are the two most important issues immediately confronting doctors in Florida, and since these issues will be resolved on a state legislature rather than a local or national level I will limit the discussion to the evolution of a physician-state legislature.

Are physicians suited to be politicians? Physicians think that we are. Doctors have had to demonstrate a certain individualistic superiority when they survived the intellectual and physical obstacle course that confronted them prior to winning the M.D. degree and during their internship and residency programs. The practice of medicine requires a degree of moral uprightness equal to any profession. Physicians certainly possess the drive, energy, and intelligence to endure any political career. Most of them are endowed with the sense of scholarship and critical thoroughness that will enable them to understand and analyze any issue and to peer through the rhetorical murk, cauistry and myopic pandering of many proposed programs, laws and regulations. Physicians, therefore, are adorned with the intellectual trappings and probity necessary for statemanship.

Political craftsmanship demands more than superior intelligence, drive and moral rectitude. It requires the charisma to gather a following of supporters and funds necessary to win an election. It requires the personal equanimity and self strength necessary to tolerate the ego-effacing abuse of opponents. It requires a degree of guile, the flexibility to compromise, and an immediate sensitivity to shifts in the centers of power surrounding any issue. David Thomas, M.D., an ophthamologist-legislator from Venice, Florida, states that physicians, by nature of their background and training, "are not political animals."

Time constraints limit physician political participation. Legislative sessions average about 75 days each year. The politician who is a member of the majority party will have extra leadership duties if he or she chairs a committee. Attorney-politicians are often relieved from the daily burdens of their law practices so that they can pursue political interests beneficial to both themselves and their firms. This freedom permits them to continually hone their political skills and to strengthen their positions within the political hierarchy. Doctors are rarely granted the luxury of a full-time political career.

It is an unusual physician who has the leadership instincts, media skills, physical bearing, and repartee that we associate as attributes necessary for success in politics. I am not certain that such skills are important; but the ability to communicate lucidly, sincerely, and persuasively is a prerequisite. Persons with some or all of these qualities exist within our medical societies. We have an obligation to cull them from our ranks, and to encourage and support them in a political career.

It is an unusual physician who has the leadership instincts, media skills, physical bearing, and repartee that we associate as attributes necessary for success in politics.

The quest for political success is onerous. I talked to the three physicians who currently are members of the Florida legislature: William Myers, M.D., Bernard Kimmel, M.D., and Dave Thomas, M.D. They illuminated the burdens that will be experienced by the physician-legislator. I was impressed with the candor with which they spoke and the economic and personal sacrifice that they have tolerated in order to function both as doctors and legislators.

Dr. William Myers is a family physician who practices in and represents the people of Hobe Sound in the State Senate. He has two partners but shares cross coverage with some internists within the community. He has been in the legislature nearly eight years. During the legislative session he stays in Tallahassee from Monday to Thursday during the first month and from Monday to Friday during the last month. He returns home to practice on Fridays, Saturdays, and even Sundays during the session. When the legislature is not in session he is absent from home and practice for another week each month (except for the summer months) to perform committee work. Additionally he must attend to constituent work on a daily basis. His legislative office, which is distinct from and five miles distant from his medical office, receives an average of 50 letters each day that must be answered and which often contain requests for problem solving that must be met. A legislative assistant, which the state supports, facilitates his constituent work. When he is not in Tallahassee he attends public function breakfasts about two days each week and evening meetings four nights each week. When he campaigns for office his schedule is even more frenetic.

I asked Dr. Myers about the economic costs of running for and staying in office. His campaign expenses were $200,000; of this he donated about $3,000-4,000 of his own funds. The rest was contributed. Five years ago he calculated that the personal cost of holding office, due to loss of practice income, exceeded $35,000 per year.

The overwhelming percentage of his patients accept his political work and absenteeism from practice very willingly although some have expressed concern about his inability to be always available; some of these patients have left the practice. In general, patient acceptance has been "super."

Dr. David Thomas is an ophthamologist from Venice who has been in the House for two years. He devotes about 30% of his time to his legislative work. As an ophthamologist he has the ability to schedule his surgery at times that he is not attending to his legislative duties.

Despite the greater flexibility in his schedule Dr. Thomas has experienced loss of practice income. He also has found that some patients will not accept his absenteeism but he feels that the loss of these individuals from his practice is compensated for by the name recognition his political career offers. His campaign cost more than $70,000 of which he contributed about $11,000 of his own income.

Dr. Thomas has three small children, age eight, six, and three. His prolonged stays in Tallahassee have imposed some emotional hardships on them. Additionally his political activities engendered friction between him and his former partner.

Dr. Bernard Kimmel is a family practitioner in West Palm Beach who has served four years in the Florida House. This year he won his primary for election to the Senate but lost a close election to a trial lawyer. Like Dr. Myers, he devotes about 40% of his time to his legislative duties — which encompass time spent during the legislative season in Tallahassee and time devoted to constituent tasks during the remainder of the year. He has one partner and several other physicians in the community who help cover him during the legislative sessions. Dr. Kimmel has not calculated the exact economic loss that his political career has demanded from him and his family. His initial campaign cost $60,000 — but his Senate campaign cost over $200,000; almost all of this was raised by political contributions.

Like Dr. Myers he commutes home on weekends to practice during the legislative session. Most of his patients have adapted to his political career although some grumbled and transferred to other physicians during the early days of his office term.

All three physician legislators were enthusiastic

about their own political participation and each encouraged other physicians to involve themselves in electoral politics, even though politics has extracted enormous quantities of time and a considerable economic loss. Politics obviously energizes these three individuals. Medicine needs more of them.

If doctors fail to deeply commit themselves to politics we will be reduced to mere factotums in our own profession.

Physicians have not done well during this electoral season. Tully Patrowicz, M.D., of Mt. Dora, and Roy Campbell, M.D., of Palatka, lost primary contests. Dr. Kimmel lost his election for the Senate. We have only two physician legislators remaining. This number is disastrously puny. Medicine is a major industry of any state but the economics of Florida and its large elderly population make medicine an even greater concern here. Additionally the legislature is considering an overhaul of the indigent medical care system; some estimate the costs of a new indigent care program are as high as $500,000,000 per year. It is ludicrous to entrust the implementation and planning of this huge program to bureaucrats and politicians with little medical insight. The national Medicare and Medicaid programs were designed with inadequate input from physicians and organized medicine; the current ineffectiveness and bankruptcy of the national medical programs were predicted by our medical leaders in the 1960s but those leaders lacked political force. If doctors fail to deeply commit themselves to politics we will be reduced to mere factotums in our own profession.

Several articles in this series on medical economics have addressed the political ineptness of physicians. In searching for reasons for our impotence I searched out a legislator who currently is not a candidate for office and yet has had extensive experience as a nonmedical politician. Former state senator Edgar M. Dunn kindly granted me a sizable chunk of a Sunday afternoon to discuss the Florida legislative political process. Mr. Dunn completed 12 years in the legislature in 1986. He has opposed physicians on the tort reform and several other issues and is perceived by physicians in Volusia County as being rather "unfriendly" to medicine. His views, therefore, provide a counterbalance to our own biases and a glimpse into the mental mechanisms of one who has opposed our interests. Mr. Dunn canonaded physicians with a few legitimate criticisms. First, he blamed us for being detached from the political process. He asserts that the medical community inserts itself into politics only when an issue arises that threatens our economic well being. At other times doctors demonstrate little interest in politics and assume little or no responsibility for making government work.

Secondly, when medical issues do arise, physicians (like most special interest groups) respond negatively — by trying to "kill" legislation rather than by confronting the societal issue and implementing legislative solutions to the needs.

Third, doctors contribute very little money to political campaigns. He states that most legislators look at the average physician's campaign contribution of $25-75 as a "a joke." In contrast, during his recent unsuccessful campaign for state Attorney General, he received an average contribution of $356.

The perceptions about physicians, as listed in the above three criticisms, have deprived doctors of credibility with legislators. We, as doctors, may disagree with Mr. Dunn's statements but we must acknowledge their existence if we are to receive the legislative attentiveness that we think we deserve.

We can continue our bilious rantings and cower and retreat from an abrasive and crepitant political system or we can galvanize our members, unbutton our treasuries and commit the sacrifices that will be necessary to recoup the political influence which we enjoyed in years past.

Mr. Dunn made other observations about physicians and politics. He stated that doctors, by virtue of their education, training and profession, expect instant rewards from the political process. If physicians involve themselves in politics, they need to commit for the long term and recognize that the pace of political change is closer to a sluggish saunter than to an explosive gallop. Furthermore doctors must expand their horizons of expertise to encompass a breadth of issues that transcend the field of medicine. They need to develop interests and knowledge in areas such as roads, education, and the environment, that affect the entire citizenry rather than just the doctors.

Physicians as a class have two choices: we can continue our bilious rantings and cower and retreat from an abrasive and crepitant political system or we can galvanize our members, unbutton our treasuries and commit the sacrifices that will be necessary to recoup the political influence which we enjoyed in years past.

We must recruit and vigorously support more physician legislators. We have two years in which to organize a statewide political effort. The state FMA leaders should identify seats in both houses of the legislature that may be assailable. Each county medical association would have the responsibility of recruiting and supporting physician candidates. Perhaps the high economic cost of serving as a candidate and legislator could be defrayed by

contributions of individual doctors in each county so that the candidate and legislator could receive support in the same fashion as do lawyers who are supported by their partnerships. A $50 contribution from 300 members of a medical society could replace $15,000 of the income that will be lost by a political career. This sum plus the $18,900 income that each legislator receives could ease the economic blight that afflicts the politician. Hopefully local physicians would also assist in the raising of funds necessary to conduct any campaign.

Funds used to elect physicians directly will be more efficient in influencing legislation than will contributions to political action committees or to the support of lobbyists, marches, etc. The legislative impact of the pleadings of a lobbyist or special interest group member is as forceful as the thrust of a stick of oversteamed linguine when it is compared to the influence of the requests and comments of a fellow legislator. The legislature is a special club where power is wielded by the respect, trust, and political bartering of the members. If doctors can elect a dozen or more of their own species to the state legislature, we can exercise control over the political future of medicine within this state. Either we commit ourselves to the political process or we gamble the political and economic future of medicine in a dice game loaded to the advantage of others.

Jacques R. Caldwell, M.D.
Daytona Beach

University of Miami School of Medicine — Council on Clinical Cardiology, AHA

NINETEENTH TEACHING CONFERENCE IN CLINICAL CARDIOLOGY

February 25-28, 1987 — Sheraton Bal Harbour, Bal Harbour, Florida

AN UPDATE IN CARDIOLOGY FOR THE PRACTICING PHYSICIAN INCLUDING CARDIOVASCULAR EMERGENCIES

Problems commonly seen by the practicing physician including Bedside Diagnosis, Coronary Artery Disease, Hypertension, Valvular Heart Disease and Current Concepts in Therapy.

SPECIAL FEATURES

- Comprehensive Review of Cardiology including Cardiovascular Emergencies
- "HARVEY," the Cardiology Patient Simulator
- Correlations of Physical Findings with Echo-Doppler
- Review of Hypertension
- Symposia on Advances in Treatment of Angina, Infarction, Arrhythmias and Congestive Failure
- Workshops on ECG, ECHO and Bedside Diagnosis
- Patient Management Problems
- Abstracts and Self-Assessment Questions and Answers for Each Lecture
- 28 Hours of AMA and AAFP Category I Prescribed Credit
- Registration Fee $400

GUEST FACULTY

Gordon A. Ewy, M.D.
University of Arizona College of Medicine

Robert J. Hall, M.D.
Texas Heart Institute

Joel M. Felner, M.D.
Emory University

Ray W. Gifford, M.D.
Cleveland Clinic

Robert G. Tancredi, M.D.
Mayo Medical School

PLEASE SEND ME MORE INFORMATION ON THE 19th TEACHING CONFERENCE IN CLINICAL CARDIOLOGY BEING HELD FEBRUARY 25-28, 1987

Name: _____

Phone: () _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Michael S. Gordon, M.D.
University of Miami School of Medicine
P.O. Box 016960 (D-41)
Miami, Florida 33101
Telephone: (305) 547-6491



It Shouldn't Even Be a Contest

You want what's best for your patients—not what's cheapest. Medicine shouldn't be practiced any other way.

Yet today's physicians are wrestling with a troublesome array of cost-containment initiatives: fee freezes, arbitrary caps on Medicare reimbursement, even restrictions on access to care. The stakes are high—life or death.

The AMA is in favor of cost-effectiveness, but not at the expense of quality care—or physicians' freedom to provide it. So we're acting, not reacting—by delivering cost-effectiveness information at special workshops and annual meetings; by offering publications including the Physician's Cost Containment Checklist; and by launching programs, such as the Cost-Effectiveness Network for hospital staffs to test cost-effectiveness strategies, and the Health Policy Agenda for the American People, a long-range set of directions and priorities for health care.

In Washington, D.C., and in court, we're fighting government-imposed fee freezes and other attempts to restrict the rights of physicians and patients.

You can fight back—by joining the AMA. Together, we'll help make sure that quality wins—every time.

For information, call toll-free 800/621-8335 (in Illinois, call collect 312/645-4987), or return this coupon to:

The American Medical Association

Division of Membership
535 North Dearborn, Chicago, Illinois 60610

Please send me AMA membership information.
☐ I am a member of my county medical society.

Name

Street

City State Zip

County

14-058

Physicians' Confidential Assistance

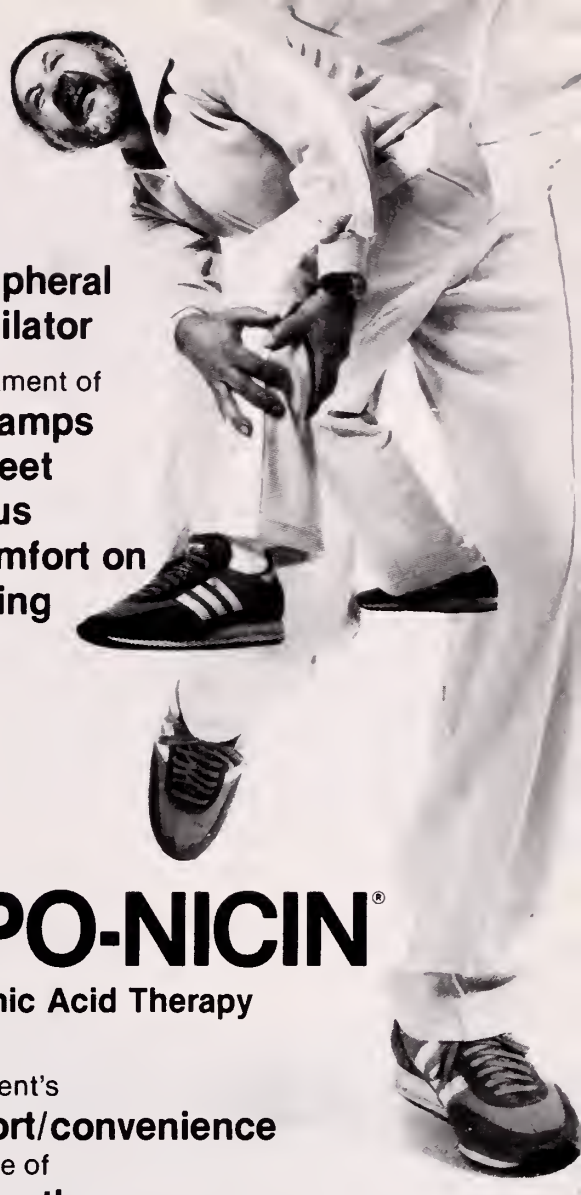
THE FLORIDA MEDICAL ASSOCIATION, INC. 1874 — M D

THE FLORIDA MEDICAL FOUNDATION 1956

Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

FLORIDA MEDICAL FOUNDATION
Needs Your HELP!

Please help by buying and encouraging others to buy:

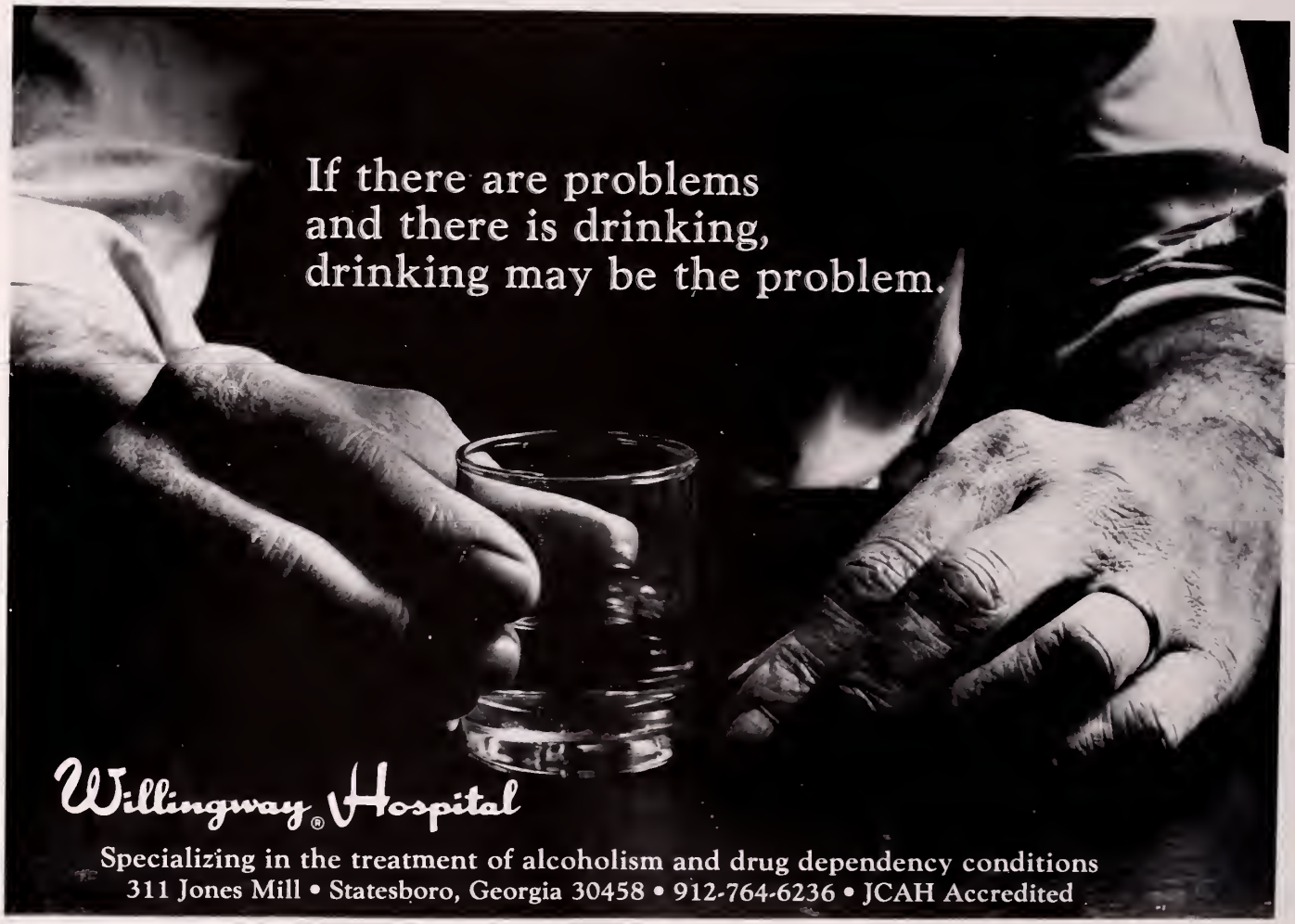
Healthy Florida Citrus

The citrus is available throughout the year and can be mailed directly to your family and friends. Order now for Christmas. These are 25% tax deductible to the donor.

REMEMBER, of all the worthy Auxiliary projects, supporting FMF is the one thing we do for our "own." One of the most important uses of the profits is to support the Impaired Physicians Program.

Please continue to order citrus throughout the year. If you need brochures or order forms, contact your local auxiliary or:

Mrs. George R. Wilson (Priscilla)
2690 SR 13
Switzerland, FL 32043
(904) 268-8665





Freedom from pain

Just one part of pain relief therapy.

Vicodin® provides greater patient acceptance

COMPARATIVE PHARMACOLOGY OF THREE ANALGESICS

	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- Vicodin offers: less nausea, less sedation, less constipation.

...and longer lasting pain relief– up to 6 hours.

- Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.[1]
- In a double-blind study, Vicodin (2 tablets), provided longer lasting pain relief than 60 mg. of codeine.[2]

Plus...

- Vicodin offers the convenience of CIII prescribing.
- Dosage flexibility–1 tablet every 6 hours or 2 tablets every 6 hours (up to 8 tablets in 24 hours).

Vicodin®

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

The original hydrocodone analgesic.

Specify "Dispense as written" for the original hydrocodone analgesic.

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk, therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur, they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. S685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.



Knoll Pharmaceuticals
A Unit of BASF K&F Corporation
Whippany, New Jersey 07981

knoll®

BASF Group

© 1986, BASF K&F Corporation 5768/9-86 Printed in U.S.A.

vicodin® II

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

Motrin® 800 TABLETS mg

ibuprofen



Extra strength
Convenience
Economy

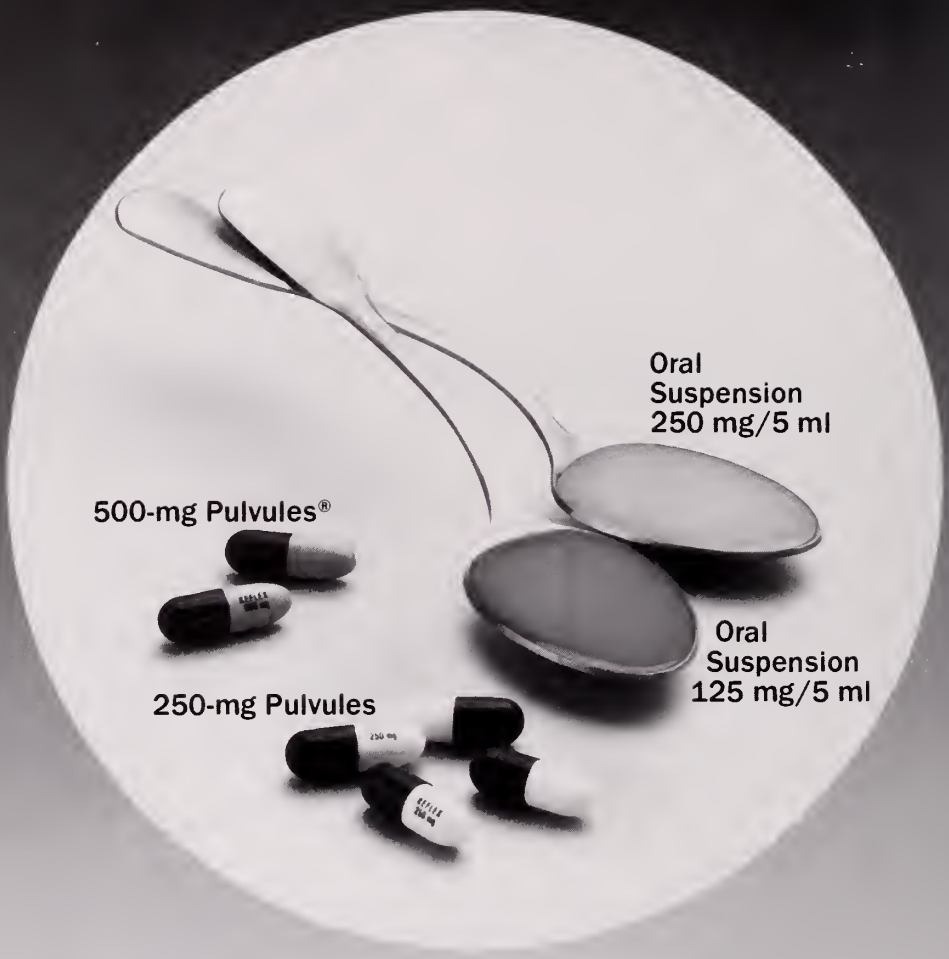
Upjohn

A Century of Caring
1886·1986

©1986 The Upjohn Company

J-6138 January 1986

Easy To Take



Keflex®
cephalexin

Additional information available to the profession on request.

DISTA
420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

FLORIDA MEDICAL

DEPARTMENTS

- ☐ NOTES & NEWS, 879
- ☐ DEAN'S MESSAGE, 880
- ☐ ENCORES!, 881

☐ NOTES & NEWS

A. Jay Block, M.D., named ACCP President-elect

On Wednesday, September 24, at the annual Administrative Meeting and Election of Officers of the American College of Chest Physicians, A. Jay Block, M.D., FCCP, Gainesville, was named President-elect. His term of office as President will start at ACCP's 53rd Annual Scientific Assembly, October 26-30, 1987 in Atlanta.

Dr. Block is Professor of Medicine and Anesthesiology and Chief, Division of Pulmonary Medicine, University of Florida College of Medicine; and Chief, Pulmonary Division, Shands Teaching Hospital, Gainesville. He received his doctorate in medicine at Johns Hopkins University, Baltimore; interned at the Osler Medical Service, Johns Hopkins Hospital; and completed residency training at Johns Hopkins Hospital. A recognized expert on sleep breathing disorders, Dr. Block has served on the Editorial Board of *Chest*, the journal of the American College of Chest Physicians; currently serves on the Editorial Board of *Pulmonary Perspectives*, a self-assessment periodical; and performs editorial review for nine other medical journals.

This year, the American College of Chest Physicians honored Dr. Block with the Louis Mark Memorial Medal and Lectureship, presented at the 52nd Annual Scientific Assembly, September 22-26, 1986 in San Francisco. He has also been honored by the University of Florida College of Medicine, the American Thoracic Society, Miami Valley Lung Association, and Wright State University, Dayton.

Dr. Jack Hickman dies

Jack W. Hickman, M.D., 55, deputy dean for faculty relations and professor of medicine at the University of South Florida College of Medicine, died in early October. A member of the charter faculty of the College of Medicine, Dr. Hickman came to Tampa from the Indiana University School of Medicine, where he was associate professor of medicine, director of postgraduate medical education and assistant dean for student affairs.

At USF Dr. Hickman served as associate dean for student affairs and house staff affairs and was a former president of the USF College of Medicine Faculty Association. Dr. Hickman also served on the board of directors of the Hillsborough County Heart Association, the Southwest Florida Blood Bank, the Hillsborough County Diabetes Association and the Hillsborough County Cancer Society and was a trustee of Wabash College. He was a fellow of the American College of Physicians, a diplomate of the American Board of Internal Medicine and the author of a book, *Academic Ceremonial Maces in the United States*. Dr. Hickman also held membership in the American Medical Association, the Florida Medical Association, and the Hillsborough County Medical Association.

He is survived by his wife, Mary Landers, a son, William L., two daughters, Anne Brinkerhoff and Elizabeth, and his mother, Mrs. Walter Hickman.

Judith Graham Pool postgraduate research fellowships available through the National Hemophilia Foundation

The National Hemophilia Foundation is currently accepting applications for the Judith Graham Pool postgraduate research fellowship in hemophilia for the 1987-1988 academic year. The deadline for submitting this application is January 15, 1987. Fellowships of up to $25,000 will be awarded through medical and graduate schools for clinical or basic research on the biochemical, genetic, hematologic, orthopedic, psychiatric or dental aspects of the hemophilias or von Willebrand's disease. Other permissible areas include research into rehabilitation, therapeutic modalities, AIDS research with respect to the hemophilias or social features of these disorders.

For further information on who is eligible and how to apply, please contact the head of the hematology/oncology department in your institution or contact: Lisa Flam, Director of Program and Chapter Development, The National Hemophilia Foundation, The Soho Building, 110 Greene Street, Room #406, New York, NY 10012, (212) 219-8180.

National Institute of Aging directory published

As health care costs continue to rise, more older adults are monitoring their health care as a means of cost containment. Through self-care, older people can enhance their sense of well-being and their ability to lead independent, active lives.

In response to a growing need for information, the National Institute on Aging has published *Self-Care and Self-Help Groups for the Elderly: A Directory.* The directory provides details about organizations that deal with the concerns of older people or that have programs relevant to older people, their families, and health professionals who work with them. It is not intended to be all-inclusive, but covers a broad variety of national organizations.

This publication is available free of charge by contacting the: NIA Information Center /SCSH, 2209 Distribution Circle, Silver Spring, MD 20910, (301) 495-3455.

Annual Meeting program correction

The FMA Annual Meeting program incorrectly listed the officers of the Florida Endocrine Society. The current President is Paul Jellinger, M.D., Hollywood, and the current Secretary is John Janick, M.D., Port Charlotte.

DEAN'S MESSAGE

Biomedical research at the University of Miami School of Medicine — a brief but successful report

The 1985-86 academic year which ended on May 31, 1986, was characterized by the largest increase in sponsored program activity in the history of the School of Medicine. In 1984-85, the Medical School recorded both direct and indirect funding totalling nearly $37 million, plus $3 million in VA research support for faculty at the Veterans Administration Medical Center. This year the Medical School awards were nearly $45 million for the Medical School and $3 million at the VAMC. The total of $48 million represents a more than 20% increase from the prior year and is the largest increase ever recorded. The School's previous best was $35.6 million in the 1981-82 fiscal year. The volume of awards increased from 481 to 509, higher than any prior year in the School's history. Equally important for the future is the fact that the number of grants submitted increased from 559 to 625 (increase of 11.8%), with a total request $260,506,000 compared to $195,407,000 in 1985 (increase of 33.3%).

The reasons for the extraordinary increase in our research awards and productivity are multifaceted, but include the superb quality of our faculty, a substantial increase in the number of proposal submissions, a doubling in the number of funded pharmaceutical studies, major increases in support of our AIDS Program and increases associated with the recruitment of more than 50 new scientists during the past five years. This increase in sponsored programs' activity is all the more remarkable when viewed against the background of level federal funding of new grants and cuts initiated on competing and non-competing renewals and contracts in response to the Gramm-Rudman legislation. Along with this increased activity, the Medical School experienced a 25% increase in the number of Ph.D. graduate students and a similar increase in the number of new M.D.-Ph.D. students.

The School of Medicine also completed the major part of the recruitment being undertaken by its basic science departments. The Departments of Microbiology and Immunology, Pharmacology, and Cell Biology, which are rapidly reaching the number of positions and strength envisioned a few years ago, were able to attract many of the brightest scientist-educators in the country.

Special note should be made of certain individual and program successes. These include acquisition or successful competitive renewal of several multi-million dollar program/projects and center awards. Included among these are the Drug Discovery Program for AIDS Research, an increase in the Robert Wood Johnson Early Intervention Program of nearly $1.5 million for the Department of Pediatrics, a Neonatal Intensive Care Unit Network awarded to Pediatrics, and the Miami Project for Spinal Cord Regeneration. The latter program led to the recruitment of an internationally-recognized team of scientists headed by Dr. Ake Seiger from the Karolinska Institute in Sweden. The major focus of their research will be on neuroregeneration. Particular note should also be made of the prestigious Jacob Javits Congressional Awards in the Neurosciences given by the National Institutes of Health to Myron Ginsberg, M.D., Department of Neurology, Ellen Barrett, Ph.D., and John Barrett, Ph.D., both of the Department of Physiology and Biophysics. Also of note was the funding of four 10-year NIH merit awards to Wade Parks, M.D., Ph.D., Department of Pediatrics, Diana Lopez, Ph.D., Department of Microbiology and Immunology, Una Ryan, Ph.D., and Margaret Fischl, M.D., both of the Department of Medicine.

Faculty of the Medical School were awarded eight of 22 (36%) Applied Research Programs funded under the Florida High Technology Council's inaugural competition. this success may be measured against the 11 awards received by Florida State University and the University of Florida, combined.

The arrival of Dr. Carl Eisdorfer, Chairman of the Department of Psychiatry, has permitted a rebirth of a University-wide Aging Center, with special emphasis on research in Alzheimer's disease, an area in which Dr. Eisdorfer has an international reputation.

The recruitment of Dr. William Eaglstein as Chairman of the Department of Dermatology and Cutaneous Surgery will permit the development of a multidisciplinary program in wound healing. This is particularly important because such studies are essential to the School's Burn Program, activities in Diabetes, and are in concert with major initiatives undertaken by the Division of General Surgery.

Among several new programs of service to the faculty of the Medical School initiated in this academic year, one stands out as an exciting stimulus for scholarship and research. The Medical Faculty Colloquium provided a monthly forum in which faculty members conferred with internationally-recognized scientists. The visitors were selected by the faculty and included many of today's leaders in the biomedical sciences.

This is only a brief recap of an extraordinary biomedical research year for our School of Medicine. We look forward to reporting even more achievements in the future.

Bernard J. Fogel, M.D.
Vice President for Medical Affairs
Dean, School of Medicine
University of Miami

Robert Rubin, Ph.D.
Deputy Dean for Research
and Graduate Studies
University of Miami
School of Medicine

ENCORES!

In search of eloquence

Physician writers are unusual creatures. The power and influence of a well-wrought article is enormous, yet doctors vigorously eschew this art form.

Physicians have been pilloried for over 50 years for their inability to communicate. Actually doctors communicate quite well — but to their colleagues rather than to their patients or other medically untutored folk. Physicians, after all, have immersed themselves in the argot and arcania of science since their high school and college days. Proficiency in the science of medicine requires fluency in its language. It is hardly surprising that physicians speak in a tongue that is shrill and incomprehensible to people who have spent most of their conscious hours in pursuits other than medicine.

When one observes the premedical and medical school curricula, which are so heavily baggaged with technology, it is surprising that physicians can communicate at all. When I was a member of the medical school admissions committee, I noted that applicant scores on the verbal section of the MCAT tests were frequently 150-200 points lower than their mathematical or scientific achievement test scores. It is a fitting testimony to their intellectual energy that many physicians can write or dictate more than a four to five sentence paragraph.

Despite the verbal handicaps imposed by their background and training, many physicians are very skillful in presenting ideas with well-crafted writing. Some physicians, such as Richard Selzer, Bernie Siegel and Elisabeth Kubler-Ross have written major books that have been extraordinarily popular. Unfortunately, none of these works has qualified as high literature but the doctors had messages to transmit and did so with lucid styles. So doctors can write and all of them possess the intellectual microcircuitry to write very well. It is motivation that is needed.

What motivates doctors, whose schedules are crammed and whose time is skimpy, to write? I never asked myself that question until one glistening autumn Sunday a year ago when my 15 year old son (who speaks only in three to four word phrases with each bisyllable punctuated by a primeval grunt) questioned me with "Whya writin' 'nudda' pap'r?" At the time I was trying to force feed my writers-blocked brain into a creative frenzy so that I could meet one of Remy Lacsamana's editorial deadlines. So initially I dismissed the question as an idle comment from a Florida teenager with a sunincinerated mind, whose highest ambition is to surf Oahu's Bonsai pipeline. Thus, I babbled an incoherent response to him but a few moments later I was truly bewildered.

Why do I write? Why should any doctor write other than scientific articles?

No physician writer has ever been crowned with the Nobel laureateship in literature. The fame earned from writing is thin since the readership is usually highly eclectic, being limited to a few physicians and perhaps their families. At times, I am stuck with the solipsistic horror that there is no one out there except the editorial and typesetting staff that reads the material that we write. Furthermore writing threatens us with some downside risk. In writing we rarely generate a totally new and quotable insight into a given topic; in contrast, the chance exists that we will write something utterly stupid, factually wrong, or judgmentally ludicrous which will permanently brand one as an ass.

Writing requires effort and few people are so gifted that their paragraphs flow uninterruptedly from beginning to end without struggle, verbal anguish, or spasms of total mental blankness. Good writing requires hard scholarship. If a man wants to express his ideas, writing compels him to flesh out weak spots in the premises of his syllogisms with thorough research and a more detailed reflection about the con-

clusions that he deduces. For a scholar, the commitment to paper is a serious undertaking in which he bares not just his creativity but also the intensity of his devotion to his task and the analytical agility of his thought process. Most articles require 10-40 hours to complete the research, writing, and interminable editing. For a physician, that time might better be spent risking sun stroke on the tennis courts, flexing the myocardia and crunching the cartilages with a few miles of jogging, or preserving a marriage by interacting with members of the family. So why do we write? One can even recite the differential diagnosis of the Bible's seven deadly sins but still not find any motivation to write from the exuberant pursuit of any of them.

I guess most of us write because of vanity and logophilia. Writing burnishes our vanity because writers are pretentious enough to believe that they have a message that must be disseminated. At times of social turbulence, such as the current era for medicine, people start to focus on social, political, and economic issues. As they think, new ideas start to gurgle up from previously undisturbed recesses of the soul and the urge to publicize those views becomes overpowering. Celebrity is a benefit that accrues to a few writers of works directed at the lay public but that reward escapes most medical authors. Also writing can become a source of confidence for the author because the effort it entails distinguishes him from his colleagues. Writing forces a man to become more certain of his ideas because of the additional burden that the scholarship imposes. In these ways writing shines one's ego but the egocentric rewards are really few.

Some of us write for the pleasure of words. Logophilia, however, can be an absolute impediment to social, intellecutal, or discursive success. An example is the individual whose Broca's area seems to sprawl across the entirety of his/her cerebral cortex. Prick this hairtriggered verbal howitzer with any question or comment and a barrage of words explodes upon the listener that totally annihilates any opportunity of mutually enriching dialogue.

On the other hand, well selected words, pithily linked together, are aesthetically wonderful products of human thought. The reading of a finely formed sentence is as pleasurable as watching the promenade of an elegant lady. The playwright, Thomas Stoppard, reminded us that "writers are not sacred, but words are."[1] The right word properly placed in the right phrase can lift a hopeless man's spirits, quench a child's storm of tears, flood a man's soul with ecstasy, arouse armies, or topple tyrants. Words are the plaits that are woven into the intellectual quilt of civilization. Words therefore become everlasting while man is enfeebled by his own mortality.

When one contemplates the power of the well-carved phrase it is surprising how banal our daily language is. A physician can stand up and talk upon his area of expertise for thirty minutes but ask him to transform the same thoughts into written prose and the translation from the oral to the written becomes a multi-houred tedium. Why? "Speech epitomized by the expandability of words."[2] Speech frequently discourages economy of expression while writing demands it. Speech is frequently allowed to violate syntax but writing strictly adheres to it. When we listen to the average speech or read the average book or magazine article the language sags with drabness. The adjectives are pale; the verbs, limp and passive; the rhythm, as lifeless as Gregorian chant. When one listens to the speech of our public figures or leaders we hear only the monotony of teleprompter oratory. Even the "great communicator," Ronald Reagan, projects vapidly when he speaks. Contrast his style with the thumping cadences of Winston Churchill's parliamentary addresses, or remember the short, forceful, jablike phrases of Jack and Bobby Kennedy. Jack Kennedy had a mediocre mind, was an uninspiring senator, and an ineffectual president; but when he spoke excitement surged through his listeners. Robert Kennedy possessed the same style. Few public figures, with the exception of New York's Governor Cuomo and Jesse Jackson, can so forcefully strum the aural pleasure strings of the their audiences.

Medicine needs doctors who have a zest for words. We need doctors to talk for us in front of congressional committees, legislatures, and consumer groups. We need doctors who can write and crystalize the confusing issues of today into lucid prose. We cannot allow surrogates who lack the passion and life-long commitment to medicine to represent us. We need ourselves. Most physicians who wish to expend the energy can master the art of language. Some, however, drape their verbal mastery in secrecy.

These talents are too precious to suppress. Verbal fluency is the mother of persuasion and the handmaiden of leadership. Medicine urgently needs persuasive leaders.

References

1 Stoppard, T. The Real Thing, 1983
2. Barthes, R. Writing Degree Zero. Translated by Jonathan Cape Ltd., 1967

Jacques Caldwell, M.D.
Daytona Beach

Reprinted with permission from *The Stethoscope*, Fall issue, 1986.

Let's discuss a national health service

Looking at the constraints and the influx of business and government into the medical profession I wonder whether the alternative of a national health service might not be debated more than it seems to be in the circles within which I mix.

For older persons, among whom I have the distinction or unhappiness of being, and in my role as a geriatrician and director of the Pacific Geriatric Education Center at USC, I am appalled at the complexities of health insurance. To get one's benefits requires a sharp mind, assiduity and many hours a day. The present expenditures by government through federal programs, whether they be Veterans Administration, Medicare or Medicaid, are very considerable. Canada enjoys a good national health service with which my physician friends seem to be well satisfied — certainly the consumers are. The last figure I had, which may well be much out of date, was that it consumed 8.5% of the gross national product.

In Britain, where the percentage of the GNP is conderably less than this, the physicians remain well satisfied — both specialists and the ever-growing number of family practitioners and/or GPs. There is an excellent training scheme over three years for family practitioners within practicing groups of such physicians and this training is much esteemed. Most patients are satisfied and I understood, again some years ago, that the national health service covered 93% of the country and a futher 7% had private insurance. These two seem to work well in a complementary fashion despite the political outcries about "paybeds" in national health service teaching hospitals. There are undoubtedly long waitlists for elective surgery and the British scheme might be regarded as the lowest common denominator. Nevertheless, it works quite well and I have never had any success in recruiting young physicians away by the lure of Los Angeles (perhaps understandable when you think about Los Angeles).

Obviously a national health service would be like this country, pluralistic and different from other national health services. However, I believe that the total wealth of the country and the rights of its citizens demand something better than what we presently have.

Programs in health care require continuity and continuum. Nowhere is this more necessary than in the care of the aging. To do this there is a need to weld a number of disciplines and services together which is very difficult in our present inchoate system. In both Canada and Britain, which I am familiar with, considerable steps have been made in coordination which did not exist prior to a national service.

On the debit side is clearly the threat of unemployment of physicians and many chasing the few desirable jobs and locations. However, with the ratio of physicians to population in California, for example, I do not believe that we are escaping that in this country and look toward the next two decades as becoming much worse in this respect. Thus there will be direction by scarcity of jobs or the demands of hospital corporations. Perhaps a national health service would be a better solution.

In addition, I believe that vital humanistic values will be resorted to medicine when we are not competing so vigorously against each other.

In conclusion, and thinking at the end of what I was trying to say in the beginning, I am perhaps urging more open debate of what often seems to be a most unwelcomed topic. If this occurs I believe we will move more readily into a resolution of our present constraints.

R. Bruce Sloane, M.D.
Los Angeles, California

Reprinted with permission from the *Western Journal of Medicine*, September, 1986, pg. 401.

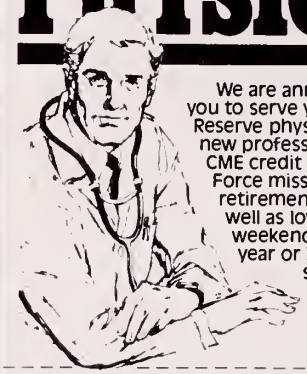
ADD NEW PATIENTS

A Nutrition Medical Centers franchise can help your practice grow. A logical extension of your professional knowledge and facilities, our proven system of nutrition counseling can create a new profit center for your practice. For more information on this exciting opportunity call (404) 872-4900.

NUTRITION MEDICAL CENTERS

1750 Peachtree St. N.W.
Suite 305
Atlanta, Georgia 30309
(404) 872-4900

PHYSICIANS



We are announcing opportunities for you to serve your country as an Air Force Reserve physician/officer. You can make new professional associations, obtain CME credit and help support the Air Force mission. For those who qualify, retirement credit can be obtained as well as low cost life insurance. One weekend a month plus two weeks a year or less can bring you pride and satisfaction in serving your country.

Call: (512) 479-3245 or (512) 385-1816 (Collect)
Or Fill Out Coupon and Mail Today!
To: Health Professions Recruiting
HQ 10 AF/RSH
Bergstrom AFB, TX 78743-6002
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Prior Service? Yes ___ No ___
Medical Specialty _____ Date of Birth _____

AIR FORCE RESERVE 10-601-1173

A GREAT WAY TO SERVE

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as relafed to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus,* volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

Book Review Editor — F. Norman Vickers, M.D.

The sounding furrows

by H. Lytle Harrell Sr., M.D.. Price $6.00 (paperback). The Pressworks Corporation, Ocala. 134 pages.

This book of memoirs will be of primary interest to many of us who know the author or members of his family. The 14 chapters cover his ancestors, his early life in Tennessee, college and medical school, marriage, family and practice in Ocala before and after World War II ending with his retirement and post-coronary bypass surgery.

There is an interesting chapter of his experiences in New York while holding a laboratory job for a year during the Depression between his junior and senior years of medical school at Vanderbilt. Apparently his social life did not suffer during that year of 1931. "Probably the biggest contribution to my popularity among my companions in New York was my supply of grain alcohol in its relative scarcity during prohibition . . . This concoction wasn't too bad and had a kick just as strong as our Tennessee White Mule. I would dish it out to my friends in bottles or other containers."

Dr. Harrell describes his practice at a lumber camp at Cumpressco about ten miles from Dade City.

The European Theater war-time experiences Dr. Harrell had were challenging. He gives examples of his own efforts at international relations in working with nine Russian doctors and many prisoners of war.

In all, these memoirs of a family doctor who practiced in Florida from the 30's to the 80's make pleasant reading.

Books are available through the author at 1142 S.E. 14th Street, Ocala 32671.

F. Norman Vickers, M.D.
Pensacola

- Dr. Vickers, a gastroenterologist, is the Book Review Editor of the *JFMA*.



DON'T GET IN OVER YOUR HEAD.

Each year, millions of people learn water safety at a Red Cross class.
Unfortunately, millions of others couldn't spare the time. What about you?

American Red Cross

AMERICAN RED CROSS CAMPAIGN
MAGAZINE AD NO. ARC-1946-85—7" x 10" (110 Screen)
Volunteer Agency: J. Walter Thompson Company, Volunteer Coordinator: William K. Pedersen, Eastman Kodak Company

CM-8-85

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Windflowers of the tropics aid AMA-ERF

Colorful, clever designs of tropical flowers cover windsocks, the latest project of the Florida Medical Association Auxiliary to raise funds for AMA-ERF. They made their debut at the 1986 Convention. These appealing windsocks are clad in an array of intense hues which are eye-teasers and pleasers, including illustrations of plumeria, hibiscus, Bird of Paradise, and orchid. They are the perfect gifts for anyone on your gift list.

The Auxiliary has found this unique way to benefit the nation's medical schools. Throughout the years, various fund raising ideas have been utilized to raise the funds that help support quality education, and this year is no exception. These very special "Windflowers of the Tropics" are available in a variety of marvelous colors and designs.

The FMA Auxiliary is proud of their successful fund raising efforts by which they contributed a grand total of $101,365.92 last year for U.S medical schools. AMA-ERF (American Medical Association-Education Research Foundation) is the only national philanthropic endeavor of the Auxiliary.

The Foundation supports three distinct funds: the Medical School Excellence Fund — grants to medical schools to be used at the discretion of the deans; the Medical Student Assistance fund — funds used in direct financial aid to students; and the Research Fund — supports pilot and experimental health and medical programs.

As Pat Durham, AMA Auxiliary President, stated in her address to the FMA Auxiliary at the 1986 Convention, "our task is to meet the challenges facing us today." One of our tasks is to help provide the financial means for educating the medical students of today who will become our physicians of tomorrow. Auxiliary AMA-ERF projects give us the opportunity to participate. By working diligently we can make our efforts successful.

Every contribution to AMA-ERF helps. It is the goal of the State Chairman to increase Florida's contribution by a minimum of 10%, and to have 100% of county auxiliaries participating in fund raising projects for AMA-ERF.

Every time you see the "Windflowers of the Tropics" waving in the breeze, you will know that another contribution has gone towards the benefit of our nation's medical schools. Solve your gift problems and help AMA-ERF. This is your opportunity to participate and show your commitment to quality medical education.

Mrs. Randall (Sue) Bertolette
FMA Auxiliary AMA-ERF Chairman
Vero Beach

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN

If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

a division of Subscription Services, Inc.

29 Glen Cove Avenue • Glen Cove, New York 11542 • 516-676-4300

Our members qualify for low professional subscription rates for magazines for office reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION	(No. of issues per yr.)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE
American Health	10	14.95	12.95	11.95
American Heritage	6	24.00	18.00	18.00
Amer.Photog.[Special:9 iss.]			7.47	7.47
Americana	6	11.95	11.95	9.95
ArtNews	12	29.95	25.95	25.95
Atlantic Monthly	12	9.95	9.95	9.95
Audio	12	17.94	8.97	8.97
AUTOMOBILE	12	24.00	12.00	
	2 yrs		22.00	
Baseball Digest	12	14.95	14.95	
for Educators: 10 issues				7.97
Basketball Digest	8	9.95	9.95	7.97
#Better Homes&Gdns	12	14.00	7.00	14.00
#BICYCLING	10	15.97	8.00	12.97
Black Enterprise	12	15.00	15.00	11.95
Boating	12	19.98	16.97	16.97
Bon Appetit	12	15.00	15.00	15.00
Boys Life	12	13.20	13.20	13.20
Car & Driver	12	16.98	11.99	11.99
Changing Times	12	15.00	9.97	9.97
#Connoisseur	12	19.95	10.00	19.95
Consumers Reports	12	16.00	16.00	16.00
#Cosmopolitan	12	24.97	15.00	24.97
Cruising World	12	18.00	18.00	14.00
Cycle	12	13.98	6.99	6.99
Cycle World	12	13.94	7.97	7.97
DISCOVER	12	23.95	13.00	14.95
Downbeat	12	18.00	18.00	9.95
EBONY	12	16.00	9.97	9.97
The Economist	52	85.00	51.00	51.00
#ELLE	12	24.00	16.00	
EM (Ebony Man)	12	24.00	19.95	19.95
ESQUIRE	12	17.94	9.95	9.95
Essence	12	12.00	9.96	9.00
Family Circle	17	14.97	9.97	
Family Computing	12	19.97	11.97	11.97
Family Handyman	10	9.95	9.95	5.95
Field & Stream	12	15.94	8.97	8.97
Fifty Plus	12	15.00	11.97	11.97
Financial World	26	41.95	24.94	
FLORIDA TREND	13	24.00	24.00	
Flying	12	18.98	15.97	15.97
Food and Wine	12	18.00	9.00	15.00
Football Digest	10	12.95	12.95	7.97
Forbes	28	42.00	42.00	28.00
Fortune	26	44.00	35.30	22.25
Games Magazine	12	15.97	15.97	15.97
Gentlemens Quartly	12	18.00	13.50	
Glamour	12	15.00	12.00	
Golf Digest	12	19.94	11.98	11.98
Golf Illus.[Special:8 issues]			5.97	5.97
Golf Magazine	12	15.94	9.97	9.97
#Good Housekeeping	12	15.97	9.97	15.97
Gourmet	12	18.00	13.50	15.00
#Harpers Bazaar	12	16.97	8.97	16.97
Harpers Magazine	12	18.00	9.97	9.97
Health [Special:9 issues]			9.97	9.97
High Fidelity	12	13.95	6.98	6.98
Home Mechanix	12	11.94	8.97	8.97
The Homeowner[Special:6 iss]			8.97	8.97
Home Viewer	12	18.00	11.97	11.97
Hot Rod	12	13.94	8.97	8.97
House and Garden	12	24.00	18.00	
#House Beautiful	12	15.97	7.99	15.97
Humpty Dumpty (4-7)	8	11.95	9.97	9.97
Inc.	12	24.00	12.00	12.00
Jerusalem Post	24	18.46	18.46	15.97
Jet	52	36.00	26.00	26.00
Ladies Home Journl	12	20.00	13.32	10.00
LIFE	12	32.50	16.25	
M (Civilized Man)	12	24.00	19.95	
Mademoiselle	12	15.00	12.00	
McCall's	12	11.95	7.95	
Metropolitan Home	12	18.00	18.00	9.00
Modern Photography	12	13.98	7.98	6.99
MONEY	12	29.95	15.00	
Mother Jones	12	24.00	16.00	16.00
Motor Trend	12	13.94	7.97	7.97
MS Magazine	12	16.00	10.97	10.97
The Nation	52	28.00	28.00	
for Educators: 24 issues				9.95
Nation's Business	12	22.00	12.97	12.97
Natural History	12	20.00	20.00	
N.E.Journal of Med.	52		60.00	
New Republic	52	48.00	48.00	28.00
N.Y. Rev of Books	17	28.00	28.00	25.95
New Woman	12	15.00	9.95	11.97
New Yorker	52	32.00	32.00	20.00
NEW SHELTER,new name:PRACTICAL HOMEOWNER				
#NEWSWEEK	52	41.00	20.80	21.85
Omni	12	24.00	15.96	15.96
1001 Home Ideas[Spec'l:8 iss]			11.97	11.97
Organic Gardening	12	12.97	9.97	9.97
Outdoor Life	12	13.94	7.97	7.97
Outside	10	16.00	12.00	8.97
Ovation	12	18.00	10.00	10.00
PARENTS	12	18.00	9.00	
Penthouse	12	36.00	30.00	30.00
People	52	56.00	56.00	28.25
Personal Computing	12	18.00	18.00	11.97
Petersens Photgrph	12	13.94	6.97	6.97
Playboy	12	25.00	21.50	21.50
#Popular Mechanics	12	13.97	7.00	13.97
Popular Photogrphy	12	11.97	5.99	5.99
Popular Science	12	13.94	7.97	7.97
#PRACT'L HOMEOWNER	9	10.97	5.50	9.97
#PREVENTION	12	13.97	7.00	13.97
PSYCHOLOGY TODAY	12	15.99	8.00	12.97
Reader's Digest	12	15.41	15.41	15.41
#Redbook	12	11.97	6.97	11.97
Road and Track	12	17.94	12.99	12.99
Robb Report	12	65.00	65.00	
The Runner [Special:8 iss.]			8.97	8.97
#RUNNER'S WORLD	12	19.95	10.00	12.97
Sail	12	21.75	21.75	21.75
Saturday Eve. Post	9	12.97	12.97	12.97
Savvy [Special:9 issues]			8.97	8.97
#Science Digest	12	13.97	6.99	13.97
Scientific Amer'n	12	24.00	24.00	24.00
Self	12	15.00	12.00	
Seventeen	12	13.95	13.95	13.95
Ski	8	11.94	6.97	6.97
Skiing	7	9.98	5.97	5.97
Skin Diver	12	13.94	7.97	7.97
SOUTHERN ACCENTS	12	18.00	16.00	
SPORT	12	12.00	7.97	7.97
Sporting News 24:6 mo		22.50	11.97	11.97
#Sports Afield	12	13.97	6.99	13.97
SPORTS ILLUSTRATED	54	58.80	34.00	29.45
Stereo Review	12	9.98	4.99	4.99
S.Porters Pers.Fin.	12	19.97	19.97	
Teen	12	12.95	7.95	7.95
Tennis	12	17.94	8.97	8.97
TIME	52	58.25	29.25	
#Town & Country	12	24.00	12.00	24.00
Travel & Leisure	12	25.00	12.50	25.00
TV Guide	52	31.20	31.20	26.00
UNIQUE HOMES	6	30.00	24.97	24.97
USA Today	260	92.00	92.00	78.00
U.S.News&World Rep	52	34.50	34.50	17.25
US Magazine	26	23.95	12.95	12.95
	2 yrs.	23.95	23.95	
Vegetarian Times	12	19.95	14.95	14.95
Video	13	12.00	8.97	8.97
Video Review	12	12.00	6.97	6.97
Village Voice	52	32.76	32.76	16.50
Vogue	12	24.00	21.00	
W Magazine	26	26.00	23.00	17.95
Weight Watchers	12	13.97	11.97	11.97
Woman's Day	17	15.13	15.13	15.13
Women's Sports	12	12.95	7.97	8.95
WORKING MOTHER	12	11.95	7.95	
Working Woman	12	18.00	12.00	15.00
World Press Review	12	16.95	16.95	14.98
World Tennis[Special:6 issues]			5.97	5.97
WORLD TRAVELING	4	11.00	9.95	9.95
Writer's Digest [Spec:9 iss.]			9.97	9.97
Yachting	12	19.98	16.97	16.97
Yankee (Colonial)	12	18.00	18.00	14.95
YM (Young Miss)	12	14.00	10.95	10.95

BUSINESS CARD NEEDED FOR OFFICE PRICE

FMA MAGAZINE PROGRAM
29 Glen Cove Avenue
Glen Cove, New York 11542

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Complete for Educator rates:

_____ Name of Educator

_____ Affiliated Hospital/School

☐ VISA
☐ M/C No. _____ Exp. Date _____

You may pay by check or credit card. Please make checks payable to FMA Magazine Program.

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

Terms: Subscriptions are one year unless otherwise noted. Prices subject to publishers' changes.
Guarentee: Our prices are the lowest, our service the best.
Renewals: Please send the address label from your magazine at least 8 weeks in advence of expiration date
New Orders: Publishers teke from 8 to 12 weeks to start your subscription.

FLMD786

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

DECEMBER

Magnetic Resonance Imaging, Dec. 1-5, 1986, Dec. 8-12, 1986, Jan. 26-30, 1987, Feb. 16-20, 1987, March 16-20, 1987, March 23-27, 1987, May 18-22, 1987,University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Refinements in Gastroenterologic Diagnosis, December 3-5, 1986, Contemporary Hotel, Lake Buena Vista. Contact: H. Worth Boyce Jr., M.D., USF Medical Center, Box 19, 12901 N. 30th Street, Tampa 33612, (813) 974-2034.

Tutorial Courses of Instruction in Acute Cardiac Care for the Practicing, Dec. 1-6, 1986, University of Miami, Miami. Contact: University of Miami, Division of CME (D23-3), P.O. Box 016960, Miami, FL 33101, (305) 547-6716.

Refinements in Gastroenterolgic Diagnosis, Dec. 3-5, 1986, Contemporary Hotel, Lake Buena Vista. Contact: H. Worth Boyce Jr., M.D., USF Medical Center-Box 19, 12901 N. 30th Street, Tampa, FL 33612, (813) 974-2034.

Innovative and Controversial Strategies in Rehabilitation, Dec. 3-7, Sheraton Bal Harbour, Miami Beach. Contact: University of Miami, Dept. of Ortho/Rehab, P.O. Box 016960, Miami 33101, (305) 547-6716.

First Annual Oncology Conference, Dec. 4-5, Grand Cypress Hotel, Orlando. Contact: Florida Hosp. Cancer Center, 500 E. Rolling Street, -305, Orlando 32803, (305) 897-7600.

Workshop on Clinical Hypnosis, December 4-7, 1986, Tampa Hilton, Tampa. Contact: Alexander A. Levitan, M.D., 2051 Long Lake Road, New Brighton, Minnesota 55112, (612) 786-1620.

Treating Cocaine Dependency, Dec. 5, Stetson University, Deland. Contact: Peggy E. Stinson, M.D., (904) 734-4121 Ext. 488.

Vascular and Pulmonary Diseases, December 5-6, 1986, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson, 5808 S. Rapp Street, -202, Littleton, CO 80120, (303) 798-9682.

Magnetic Resonance Imaging, December 8-12, 1986, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

One-day Overview of Diabetes Mellitus, Dec. 8, 1986, Feb. 16, 1987, March 27, 1987, USF College of Medicine, Tampa. Contact: Anthony Mornison, M.D., (813) 974-4360.

Emergencies in Internal Medicine, Dec. 9-15, Virgin Islands. For more info: University of Miami, Dept. of Medicine, P.O. Box 016960, Miami 33101, (305) 547-6716.

International Conference on Hypertension in the Elderly, December 12-16, Wyndham Hotel Sea World, Orlando. Contact: Bruce Robinson, M.D., (813) 974-2460.

JANUARY

Tenth Annual Oral Pathology Review, Jan. 10-14 and Jan. 31-Feb. 4, Miami. Contact: University of Miami, Division of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

High Risk Pregnancy and Brain Damage, January 15-17, 1987, Sonesta Beach Hotel, Key Biscayne. Contact: Robin Murray (202) 638-5577.

Neurological Update, 1987, Jan. 20-25, 1987, Bal Harbour. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Nineteenth Seminar in Pediatric and Adult Urology, Jan. 21-24, Sheraton Bal Harbour, Miami Beach. Contact: Victor A. Politano, M.D., 6614 Miami Lakes Dr. East, Miami Lakes, 33014, (305) 687-1367.

Introduction to Allergy Diagnosis and Treatment, January 23, Sheraton Orlando Int. Airport, Orlando. Contact: J. Alan Stewart, M.D., (713) 792-5346.

Fourth Annual Doctors Hospital Winter Seminar, Jan. 24-31, Plaza Wood Creek, Mt. Crested Butte, Colorado. Contact: George T. Venis, M.D., 2295 Coral Way, Miami 33145, (305) 856-6121.

Oculoplastic Symposium 1987, January 24-31, University of Miami, Miami. Contact: Univ. of Miami, Dept. of Ophthalmology, P.O. Box 016960, Miami, FL 33101, (305) 964-0707.

Post Convention Seminar on Adult and Pediatric Urology, January 25-28, Nassau, Bahamas. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Interdisciplinary Rape Science Institute, January 25-30, April 5-10, University of Miami, Miami. For more information: University of Miami, Division of CME, (305) 547-6716.

Risk Management for the Pathologist, January 26, University of Miami, Miami. For more info: University of Miami, Division of CME (D23-3), (305) 547-6716.

Tutorial Course of Instruction in Acute Cardiac Care for the Practicing Physician, Jan. 26-31, University of Miami, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Twelfth Annual Review and Recent Practical Advances in Pathology, January 27-31, University of Miami, Miami. For more information contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Annual Meeting of the SSPR, SSCI, Southern AFCR, January 28-30, New Orleans. Contact: John Malone, M.D., (813) 974-4360.

Sixth Annual Perspectives on New Diagnostic and Therapeutic Techniques in Clinical Cardiology, January 30-February 1, Buena Vista Palace Hotel, Lake Buena Vista. Contact: Registration Secretary, Extramural Programs Dept., American College of Cardiology, 1-800-253-INFO.

Tenth Annual Oral Pathology Review, January 31-February 4, San Francisco. Contact: Division of CME (D23-3), University of Miami, (305) 547-6716.

Thirteenth Annual Vail Conference in Anesthesiology, Jan. 31-Feb. 7, Vail, Colorado. For more information: Sonja Craythorne, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101, (305) 547-6411.

FEBRUARY

Current Clinical Concepts in OB/GYN, Feb. 2-4, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Breznen, (305) 650-6236.

Gastroenterology Update, Feb. 7, Mt. Sinai Medical Center, Miami Beach. Contact: University of Miami, Division of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Vail Symposium in Intensive Care, Feb. 7-14, Vail, Colorado. For more info: Sonja Craythorne, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6411.

Advances in Gene Technology, Feb. 9-13, Hyatt Regency, Miami. Contact: William J. Whelan, Dept. of Biochemistry, P.O. Box 016960, Miami 33101, (305) 547-6265.

Cardiopulmonary Rehabilitation Status '87, Feb. 10-14, University of Florida, Gainesville. Contact: Michael Pollock, Ph.D., Dept. of Medicine, Univ. of Florida, JHMHC J-277, Gainesville, 32610, (904) 392-0584.

Communicating with Patients, Feb. 12-13, Tradewinds Hotel, St. Petersburg. Contact: Daivd H. Smith, Ph.D., (813) 974-3294.

Current Topics in Occupational Health, Feb. 16-21, Tampa. For more information: Nicholas Alexiou, M.D., (813) 974-3294.

Conference on the Beach, February 16-21, Daytona Hilton, Daytona Beach. Contact: Tariq Siddiqui, M.D., Halifax Hospital, P.O. Box 1990, Daytona Beach 32015, (904) 254-4167.

Hepatobiliary Disease in the Clinical Practice VII, February 19-21, Bal Harbour. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Bascom Palmer Eye Institute 25th Anniversary Celebration, Feb. 19-21, Fontain Bleau Hotel, Miami Beach. For more information: Gaby Kressley, Dept. of Ophthalmology, P.O. Box 016960, Miami 33101, (305) 326-6031.

National Forum Aids and Chemical Dependency, Feb. 20-21, Royce Hotel, Ft. Lauderdale. Contact: Larry Siegel, M.D., (212) 206-6770.

Tutorial Course in Acute Cardiac Care for the Practicing Physician, Feb. 23-28, University of Miami, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Third Annual Update on Neuro-Oncology, Feb. 24-25, Tradewinds Hotel, St. Petersburg Beach. For more info: S. Phuphanich, M.D., 12901 N. 30th St., Box 69, Tampa, 33612, (813) 974-3771.

Nineteenth Teaching Conference in Clinical Cardiology, Feb. 25-28, Sheraton Bal Harbour, Bal Harbour. Contact: Virginia McCars, Division of Research in Medical Education, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6491.

Selected Aspects of Internal Medicine, Feb. 28-March 6, Colorado, Telluride. Contact: University of Miami, Dept. of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

MARCH

Internal Medicine 1987, March 1-6, Bal Harbour, Division of CME (D23-3), University of Miami, (305) 547-6716.

Three-Day Diabetes Management Course, March 3-5, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Intensive Care for Neurological Trauma and Disease, March 4-8, Walt Disney World, Orlando. For more information: University of Miami, Division of CME (D23-3), (305) 547-6716.

Eleventh Annual Midwinter Seminar in OB/GYN, March 5-7, St. Petersburg. Contact: James Ingram, M.D., (813) 974-2088.

The Heart and Brain Clinical Inter-Relationships, March 9-11, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Breznen, (305) 650-6236.

Advances and Improvements in Hernia Surgery, March 12-14, Hyatt Regency, Miami. Contact: Arthur I. Gilbert, M.D., 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Eighteenth Annual Topics in Internal Medicine, March 12-14, Hilton Hotel, Gainesville. Contact: Craig S. Kitchens, M.D., (904) 375-6247.

Cancer Conference Daytona Beach, March 13-14, Halifax Hospital Medical Center, Daytona Beach. For more information contact: Terry Bloom, M.D., (904) 254-4210.

Advances in Spinal Surgery VII, March 17-22, Bal Harbour. For more info: University of Miami, Division of CME (D23-3), (305) 547-6716.

Trauma Tactics Symposium, March 20-21, Good Samaritan Hospital, West Palm Beach. For more info: Barbara L. Breznen, (305) 650-6236.

Vascular Surgery, 1987, March 22-24, Hilton Hotel, Good Samaritan Hospital. Contact: Barbara L. Breznen, (305) 650-6236.

Diagnosing Dermatology and Infectious Diseases in Pediatrics, March 23-25, Good Samaritan Hospital, West Palm Beach. For more information: Barbara L. Breznen, (305) 650-6236.

Ninth Annual Family Practice Review, March 23-27, Holiday Inn Surside, Clearwater Beach. Contact: Charles Aucremann, M.D., 701 Sixth St. South, St. Petersburg 33701, (813) 983-6156.

APRIL

Pediatric Oriented ACLS Provider Course, April 3-5, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Practical Aspects of Newer Cardiovascular and Renal Therapies, April 5-8, Orlando. Contact: Division of CME (D23-3), University of Miami, (305) 547-6716.

Interdisciplinary Rape Science Institute, April 5-10, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Tutorial Course in Acute Cardiac Care for the Practicing Physician, April 6-11, University of Miami, Division of CME (D23-3), University of Miami, (305) 547-6716.

Issues in Prenatal Care — 1987, April 10-11, Indigo Lakes, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Blvd., Daytona Beach 32014, (904) 252-4701.

Second Congress on Sports Injuries for the Primary Care Physician, April 23-25, Village of Grenelife, Grenelife, FL. Contact: Brian C. Halpern, M.D., (904) 324-6661.

1987 Radiation Therapy Clinical Research Seminar, April 23-25, University Centre Hotel, Gainesville. Contact: Timothy A. Brant, M.D., Radiation Therapy Division, University of Florida, JHMHC J-385, Gainesville 32610, (904) 395-0287.

Miami Comprehensive Review Course in Anesthesiology, April 25-May 2, Key Biscayne. For more information: University of Miami, Division of CME (D23-3), (305) 547-6716.

MAY

Five-day Management of Diabetes Mellitus, May 11-15, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

L'Humiditemp™

Protect and age your wines in the replicated environment of a subterranean French limestone cave . . . with L'Humiditemp, a product of today's technology.



Automatic humidity/temperature control. Free standing • 300 bottle capacity • Active odor filtration • Vibration free • Screens out light. Bottle aeration • Available with Many Options.

800-243-9355 • 617-593-3333
GIRONDE BROS., INC.
319 Lynnway, Lynn, MA 01901

Dress up the holiday with Christmas Seals®.

This season the healthy look is in. Smoking is out. Nobody wants their lungs wearing black!
Fashionable cards and gifts wear Christmas Seals®
They help the American Lung Association fight all lung diseases.
Tell everyone "Healthy Holidays" with Christmas Seals®

— *Cybill Shepherd*



TAKE CARE OF YOUR LUNGS. THEY'RE ONLY HUMAN.

AMERICAN LUNG ASSOCIATION
The Christmas Seal People®

Space contributed by the publisher as a public service.

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name: _____

Address: _____

_____ Phone: _____

AD COPY

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted ☐ Real Estate ☐ Equipment

☐ Situations Wanted ☐ Art ☐ Services

☐ Practices Available

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

For further information, including rates for display advertising, call Mrs. Mary N. Fouraker, (904) 356-1571.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

MEDSTAFF HAS PRACTICE OPPORTUNITIES in an array of Sun Belt locations. Options for locum tenens and/or permanent placements in all specialties. Work fulltime or parttime. Trial associations with established practices also available. Call Virginia Williams at (800) 833-3465 (U.S.) or (800) 672-5770 (NC) or write MEDSTAFF, INC., P.O. Box 15538, Durham, NC 27704.

OPENING FOR RADIOLOGIST: Diagnostic radiologist with interest and experience in mammography and ultrasound needed to staff new radiology office. Monday-Friday, 8-5. Florida License required. Salary negotiable. Contact K. Jay Adcook, M.D., 515 S. Orange Ave., Orlando, FL 32801, (305) 425-1518.

AGGRESSIVE, YOUNG, active and motivated F.P. looking for associate for office sharing leading to formation of group. C-1347, P.O. Box 2411, Jacksonville, 32203 or call (305) 842-5252.

DO YOU WANT TO SHARE a thriving dermatology practice? Do you enjoy year-round outdoor recreation? You should contact us. . .a progressive multi-specialty group of 61 physicians in a pleasant, growing community. We offer a liberal financial package and outstanding benefits. Send curriculum vitae and references to: Michael T. Anderson, M.D., Willmar Medical Center, 101 Willmar Avenue SW, Willmar, MN 56201.

NEUROLOGIST — Established headache clinic in Tampa expanding, needs BC/BE associate with Florida license to join Senior Neurologist. Excellent practice opportunity for young neurologist with keen interest in headache diagnosis and management. First year salary with incentives leading to partnership opportunity. Send CV and personal requirements to: A. Carvel Gipson, M.D., 2727 W. Buffalo Ave., Tampa, FL 33607.

ASSISTANT MEDICAL DIRECTOR. Part-time, mostly mornings. Familiar with Broward County. Will work in our Miami office, in administrative capacity. Reply to Medical Director, Finlay HMO, 1401 Brickell Ave., Miami, FL 33131.

OTOLARYNGOLOGIST-ENT, Central Fl. Community in Central Florida seeeking ENT (Board Certified or eligible) to establish private practice in affiliation with a multi-specialty group association. Competitive practice, incentive and benefits package. Excellent location for recreational activities, yet close to metropolitan areas. Send CV to Box C-1363a, P.O. Box 2411, Jacksonville, FL 32203.

NEUROLOGIST — (Board Certified/Eligible). Neurologist to establish private practice in affiliation with a multi-specialty group association. Competitive practice, incentive and benefits package. Excellent central Florida location for recreational as well as metropolitan activities. Send CV to Box C-1363b, P.O. Box 2411, Jacksonville, FL 32203.

RADIOLOGIST — locum tenens wanted — North Florida practice with possibility of future association. Board qualified. Must have experience in all phases of Diagnostic Radiology including CT and angiography. Send CV with inquiry. C-1355, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST: Opportunity to join multispecialty group in a new and exciting concept of private medical practice in an attractive downtown Tampa office. Please send curriculumvitae to Richard Crane, M.D., 4215 North MacDill Avenue, Tampa, FL 33607, (813) 879-6380.

FT. LAUDERDALE AREA — Physician wanted for walk-in family medical center. Excellent salary and incentives. Partnership available. Contact: Mrs. King, (305) 752-1343, or send CV to C-1356, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE/INTERNAL MEDICINE, BC/BE wanted for rapidly expanding practice. Excellent patient base and unlimited potential to join young internist and GP on FL's east coast. Excellent salary and benefits. Box C-1364, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE Physician or internist needed for multi-specialty group in Central Florida. Primarily adult and industrial medicine. Florida license is required. Guaranteed income for first year with benefit package, then opportunity to join the corporation. Shared on call schedule with each on call one night per week and every fifth week-end. Send resume to P.O. Box 568908, Orlando, FL 32856-8908.

BOARD CERTIFIED FAMILY PRACTITIONER. Growing solo practice needs help. Opportunity for partnership. Immediate opening. Hallandale, FL (305) 458-0100.

PSYCHIATRIST — full-time position open for Board Certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient and limited inpatient on-call. Florida license needed. Reply to Box C-1349, P. O. Box 2411, Jacksonville, FL 32203.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

FT. PIERCE, FLORIDA — Full time emergency department position available in a 240 bed hospital with an annual ED volume of 24,000. Candidate must be board prepared in emergency medicine. The hospital is centrally located between Disney World and Miami on Florida's Treasure Coast. Excellent compensation and malpractice insurance provided. Please send CV to Cheree Richards, EMSA, 8200 W. Sunrise Blvd., Plantation, FL 33322, or call (305 472-6922.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

INTERNAL MEDICINE:Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

GENERAL INTERNISTS, FAMILY PRACTICE, GERONTOLOGIST, EMERGENCY CARE MEDICINE, PEDIATRIC SURGEON 40 physician multi-specialty Group in West Palm Beach, Florida seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send C.V. to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 North Olive Avenue, West Palm Beach, Florida 33401.

GYNECOLOGIST to take over small active practice in sunny Southwest Florida. Small investment — active group practice — referrals. Send CV to C-1368, P.O. Box 2411, Jacksonville, 32203.

INTERNIST to work in new group practice in sunny Southwest Florida. Fully equipped office. No investment. Send CV to P.O. Box 2411, Box C-1368, Jacksonville, 32203.

OBSTETRICIAN-GYNECOLOGIST, Board eligible or board certified, male or female, American or foreign trained, to join well-established practice ijn progressive community of 20,000 in eastern North Carolina with a service area of 100,000, close to Raleigh and Durham, North Carolina, and Richmond and Norfolk, Virginia. Area has excellent cultural and recreational activities. School system is among the best in the state. Excellent benefit package. Send curriculum vitae to P.O. Box 1122, Roanoke Rapids, N.C. 27870 or call collect (919) 535-2200 Monday-Friday 9 a.m.-5 p.m. or (919) 535-2273 evenings and weekends.

FLORIDA: Emergency Department position available for a primary care physician with EM experience in northeast Florida. Commute from St. Augustine, Jacksonville, or Gainesville to this 120-bed facility seeing 20,000 patients annually. Enjoy flexible scheduling, no on-call time, and annual compensation in excess of $75,000. In addition, complete professional liability insurance procured on your behalf. Contact: Kathy Valli, Coastal Emergency Services, Inc., (800) 328-1038 in US or (800) 432-3093 in FL; 2200 W. Commercial Blvd., Ste. 203, Ft. Lauderdale, FL 33309.

OPPORTUNITIES AVAILABLE for two psychiatrists — 1) General Adult Psychiatrist; 2) Child and Adolescent Psychiatrist. Board Certified/Board Eligible. Rapidly growing interdisciplinary private practice. Located in Winter Park, Florida. Affiliated with numerous facilities in the Orlando area. Possible positions for directorships and future opportunity for partnership. Must be able kto work as a team member. Good salary and benefits. For further information contact: the Group for Psychiatry, Psychology and Social Services, 335 N. Knowles Ave., Winter Park, FL 32789 (305) 644-2121.

INTERNIST WANTED: For association with four internists. Southeast coast of Florida. Board qualified. Salary: $50,000, plus a percentage. Early partnership assured. Reply: P.O. Box 768, Lake Worth, FL 33460.

WEST PALM BEACH — Caring and dedicated physician required P/T for medical clinic. Excellent hours and salary. Must love patients. W-F. Call Janet at (305) 655-8245.

Situations Wanted

VASCULAR GENERAL SURGEON, vascular surgery fellowship. Board certified, desire group practice situation in Southern Florida. Call 206-326-5891 or write S. Goff, 528 18th Ave., Seattle, WA 98122.

FAMILY PRACTITIONER, BC, Florida license looking for association, partnership or buying solo practice in Central Florida. Other areas considered. Reply, C-1198, P.O. Box 2411, Jacksonville, FL 32203.

GENERAL AND VASCULAR SURGERY with endoscopic experience. Now a chief resident in a university program. Available July, 1987. Desire solo, partnership, or group practice opportunity. C-1352, P.O. Box 2411, Jacksonville, FL 32203.

MEDICAL PRACTICE ADMINISTRATOR with over 15 years experience developing a general practice to 25,000 active pt. base seeks stable, long term situation dedicated to quality patient care and prudent business decision-making. Contact Dr. P. Callahan, Callahan & Associates, P.O. Box 1686, Largo, FL 34294, (813) 584-4275.

AUSTRALIAN FAMILY PRACTITIONER holding FL license and British MRCP in internal medicine wishes to join family practice in Orlando. Arriving in Orlando early January. Use local contact Mrs. J.D. Mahaffey, 747 Jamestown Drive, Winter Park, FL 32791.

BOARD CERTIFIED (Family Medicine) Florida License seeks 40 hour a week position in family clinics, public health, emergency room also nursing homes and locum tenens. Call or write to: Celedonio C. Barrameda, M.D., 312 N.E. Ardsley Dr., Port St. Lucie, FL 33452. Tel: 1-305-878-6608.

FORTY-SEVEN YEAR OLD OTOLARYNGOLOGIST — very experienced surgeon and clinician. Seeking group practice or ENT group in or near major city. Excellent credentials. Board Certified, university faculty. Write 4179 Lanai Road, Encino, CA 91436, or call 818-995-0758.

CHIEF RESIDENT — Urology, BE, University trained, seeking practice opportunity in Florida. Experienced in all aspects adult/pediatric urology including prosthetics, endourology and oncology. Licensed in Florida. Available 7/87. Please call: (201) 667-7863 or write: N. Terzian, M.D., 221 Harrison St., B-4, Nutley, NJ 07110.

Practices Available

TAMPA. ACTIVE FAMILY MEDICINE/GERIATRIC medical practice available with fully equipped office. North Tampa area. Physician retiring. Will negotiate terms and introduce. C-1354, P.O. Box 2411, Jacksonville, FL 32203.

PRACTICE FOR SALE: On busy corner thoroughfare. Sixteen years in practice. Family practice with general surgery. Office complete with lab facilities, including EKG, X-rays, spirometry, etc. Terms negotiable. Available immediately. Northeast Florida. C-1360, P.O. Box 2411, Jacksonville, FL 32203.

DERMATOLOGIST PRACTICE FOR SALE: Fully equipped beautifully furnished offices in prestigious doctors building ideally located. Assist in turnover. Great opportunity. Dr. J.J. Eller, 2601 N. Flagler Drive, West Palm Beach, FL 33407. (305) 832-4109.

PEDIATRICS: North Florida. Well-established practice. Will phase out. Equipment available. Building for rent or sale. Pay off over 10 years. C-1359, P.O. Box 2411, Jacksonville, FL 32203.

SUNCOAST FLORIDA — 20 yr. general practice. Location, facilities, practice, patient population all great. 1618 Dixie Highway, Holiday, FL 33590.

PEDIATRICIAN planning to retire. Seventeen-year-old solo practice for sale. 2178 square foot office building for sale or lease. Jacksonville Beaches Area. (904) 249-4570 or 241-7113.

WEST PALM BEACH — One or more M.D.'s to take over established Pediatric Practice. Located in prime area — 8 room furnished office, equipped laboratory and supplies. Rent or buy. Terms negotiable. Reply — P.O. Box 3344, West Palm Beach, FL 33402.

UROLOGIST retiring due to illness desires to sell 18-year-old solo practice. Also available: office building suitable for two physicians. Jacksonville Beaches area. (904) 249-4570 or 241-7113.

PRACTICE FOR SALE: Immediate, solo, gynecology, 8-year-old practice. Excellent opportunity for obstetrics if desired. $30,000 includes instruments, colposcope, pay in installment if desired, central Florida. C-1362, P.O. Box 2411, Jacksonville, FL 32203.

Real Estate

SPRING HILL, FL - 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease - owner will finance. (904) 596-4162 weekdays.

RETIRING BOARD CERTIFIED OB-GYN selling or leasing completely equipped office. Capacity for 2 or more Ob-Gyns. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone 305-667-3677.

PRIME OFFICE SPACE FOR LEASE OR PURCHASE: 844 West Plymouth Ave., De Land, Fl. (1 block from West Volusia Hospital) Luxury 9 2000 Sq. Ft professional office, 2 bath, 1 pvt. bath/shower, 2 executive offices with pvt. interconnecting lounge/bath-shower, 4 exam rooms, common reception area with large waiting room, common business area. Lease: $2200.00 per Mo. Purchase: $185,000. Lease/Purchase available. Interested parties: (904) 736-6110.

FOR SALE: Home, office and family practice on lovely Plantation Key. Ideal situation for semi-retired physician with a spirit of adventure. $225,000. (305) 852-7993.

SALE/LEASE — Medical Imaging facility, Ft. Lauderdale. Building and Equipment. Turn Key. Siemens-Kodak-Technicare, plus additional equipment space. Herman E. Rolfs, M.D. (904) 863-8110.

RADIOLOGY OFFICE FOR LEASE, Sale or joint venture. Rapidly growing area, hospital and 3 medical building complex: 30 physicians, C-1365, P.O. Box 2411, Jacksonville, FL 32203.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

WE BUY, SELL, LEASE SERVICE new and preowned medical instrumentation: Holter-Stress-Ultrasound-EKG Lab etc. Contact New Life Systems, Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065; 305-972-4600.

ATTORNEY FOR PHYSICIANS for business, professional regulation, records, malpractice, and standard of care issues. Vitae: Doctor of Science, Health Services Administration (University of Pittsburgh); Juris Doctor, Law (Creighton University); 20 years health-care experience; Professor; publications. Licensed to practice law in Florida, Michigan, and Nebraska. Contact: Robert Woody, Attorney at Law, Suite 205, 1950 Courtney, Fort Myers, FL 33901; telephone (813) 939-4321.

MEDICAL PRACTICE SALES AND APPRAISALS. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our Brokerage Division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004, 215-667-8630.

LONG TERM FINANCING for starting/purchasing practices, diagnostic centers, equipment, office condos, buildings. $25,000 to $1,000,000. Western Financial, 1380 Miami Gardens Drive, N. Miami Beach, FL 33179, (305) 949-5900.

Equipment

WORD PROCESSOR — SONY. Take over lease - no downpayment, series 35 partial page, dual disk drive, 55 CPS printer. 14 months on lease at $730 per quarter. Option to purchase/investment tax credit. C-1357, P.O. Box 2411, Jacksonville, FL 32203.

HOLTER MONITOR: Quality scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretation, scan price $35.00. Recorders loaned, leased or purchase new dual-channel holter recorder, $995.00 with one year warranty. For more information call collect, Advance Medical & Research Center, Inc., 1-313-373-1199.

FOR SALE: Medical Equipment and supplies, including QBC blood analyzer, A-O microscope, Burdick EK-100 EKG, defibrillator, hyfrecator, x-ray duplicator, view boxes, shelving, miscellaneous instruments, office and medical supplies. Package deal. Box C-1361, P.O. Box 2411, Jacksonville, FL 32203.

FOR SALE: JEDMED Axisonic II A Scan with rolling stand, used only 15 times. $3,500.00. (904) 824-1767 nights.

35-CM SIGMOIDOSCOPE, Flexible-Fiberoptic, Brand new, FPS-3 American Optical/ Reichert, Price: $945.00. (305) 994-2260 day or 994-6950 evening.

SALE/LEASE Medical Imaging Facility, Fort Lauderdale — Building and Equipment. Turn Keyl. Siemens-Kodak-Technicare plus additional equipment space. Herman E. Rolfs, M.D. (904) 863-8110.

RETIREMENT SALE: Ophthalmic office equipment. Operating table, halogen lamp, Mayo stand, minor surgical instruments, exophthalmometer, prisms, 4 dol. occluders, hebensoh, Ishihara, bookkeeping index. (904) 261-4278, afternoons.

Meetings

1987 CME CRUISE/CONFERENCES on selected medical topics — Caribbean, Mexico, Hawaii, Alaska, China/Orient, Scandinavia/Russia. 7-14 days year round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) and AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican & Alaskan cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746 (516) 549-0869.

BIOFEEDBACK THERAPIST TRAINING WORKSHOP — Four day program to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. Medical CEUs pending. September 25-28 or November 13-16, 1986. Tentative 1987 dates: February 6-9, April 24-27, or June 12-15. For brochure contact: Hartje Stress Clinic, 2429 University Blvd. West, Jacksonville, FL 32217. (904) 737-5821.

Miscelleneous

MEDICAL-APOTHECARY antiques and collectibles for sale. Huge assortment of 1800s to early 1900s items. Visit the Medical Corner, Hollywood Antique Mall, 2031 Harrison St., Hollywood, FL 33020 (305) 922-6255.

Heart Healthy Recipe

STUFFED PEPPERS

4 tablespoons corn oil
2 onions, sliced
2 cloves garlic
1 zucchini, diced
4 tomatoes
2 cups cooked brown rice
½ cup cheddar cheese, grated
4 large green peppers, seeded
2 cups tomato juice

Heat oil in large skillet over medium heat, and sauté onions, garlic, zucchini and tomatoes. Combine rice and cheese and add to the above mixture.

Stuff peppers with the vegetable mixture and replace pepper top. Pour tomato juice into the bottom of a casserole dish. Place peppers in casserole.

Bake for ½ hour at 375°F.
Yield: 4 servings
Approx. cal/serv.: 325

Heart Healthy Recipes are from the Third Edition of the American Heart Association Cookbook. Copyright © 1973, 1975, 1979 by the American Heart Association, Inc.

American Heart Association

WE'RE FIGHTING FOR YOUR LIFE

YOUR NEW LOW DAILY RATES AT AVIS START AT $33.00



Avis features GM cars. Buick Century.

Your association membership means new, uniform low flat rates at Avis. And there's no charge for mileage. Choose from subcompact through full size 4-door car groups:

DAILY RATE	
SUBCOMPACT (Chevrolet Chevette or similar)	**$33.00**
FULL SIZE 2-DOOR (Buick Century or similar)	**$39.00**

These uniform low flat rates make it easy to know your rate before you go. To reserve a car, call Avis toll free: ***1-800-331-1212***

Be sure to mention your Avis Worldwide Discount number: **A/A616900.**

AVIS ***WE TRY HARDER.***®

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. Flat rates are nondiscountable and are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. An additional charge per day will apply in certain locations including Newark Airport, NJ; LaGuardia Airport, NY; Kennedy Airport, NY; and all Manhattan locations. Check with Avis for the amount. Rates, discounts and additional charges subject to change without notice. Cars must be returned to rental location or higher daily rate and a one-way service fee will apply. Cars and particular car groups subject to availability. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

© 1985 Avis Rent A Car System, Inc., Avis®

ADVERTISERS

Air Force Reserves
Recruitment . . . 884

Army/Army Reserves
Recruitment . . . 836

AT&T
Service . . . 826

Ayerst Laboratories
Inderal LA/Inderide LA . . . 822a
Premarin . . . 846b

Brown Pharmaceutical
Android . . . 829
Lipo-Nicin . . . 877

BellSouth Mobility
Service . . . 830

Eli Lilly & Company
Keflex . . . 878d

Fair Oaks Hospital
Service . . . 823

First Defense Legal Services Insurance Corp.
Service . . . 838

FMA Sponsored Insurance Plans
Service . . . 860

Florida Physicians' Insurance Company
Service . . . 822

Florida Power Corporation
Service . . . 844

GTE Telenet
Service . . . 869

Gironde Bros., Inc.
L'Humiditemp . . . 891

Gulf Coast Diversified, Inc.
Service . . . 837

Health Cap
Service . . . 846

Knoll Pharmaceutical Company
Vicodin . . . 878a

Marion Laboratories, Inc.
Cardizem . . . 838a

Nutrition Medical Centers
Service . . . 884

Roche Products, Inc.
Dalmane . . . 899

Smith, Kline and French Company
Dyazide . . . 846a

Ster-O-Lizer
Equipment . . . 845

University of Miami
Seminar . . . 829,870,875

Upjohn Company
Motrin . . . 878c

Willingway Hospital
Service . . . 878

Florida Medical Association Officers and Council Chairmen

Officers

James B. Perry, M.D., Ft. Lauderdale, President
James G. White, M.D., Ormond Beach, President-Elect
Kay K. Hanley, M.D., Clearwater, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Charles P. Hayes Jr., M.D., Jacksonville, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
Thomas D. Bartley, M.D., Gainesville, Specialty Medicine
Thomas M. Daniel, M.D., Clearwater, Hospital Medical Staffs

ROCHE
ME
MEDICATION
EDUCATION

The *New* Roche Product Books

- **Offer a supplement to, not a substitute for, patient contact**
- **Support your specific instructions to the patient**
- **Provide a permanent general reinforcement of your oral counseling**

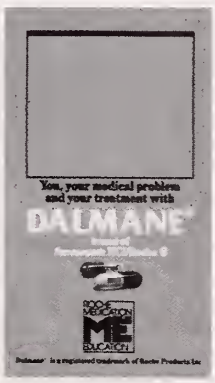
An ongoing Roche commitment to patient education

Roche has always believed that knowledge is each individual's key to good health and has long been committed to providing health care information to both professionals and the public. However, we have also always believed that the health care professional is and should be the prime source of medication information to patients. The Roche Medication Education (ME) program, begun in 1978, is one example of this commitment.

In the past seven years, over 50 million "WHAT IF" and "HOW TO" booklets have been provided by Roche for distribution to patients by physicians and other health care professionals.

Because you are the prime source of medication information for your patients, we invite you to look over the booklets listed below and request a complimentary supply of those applicable to your practice.

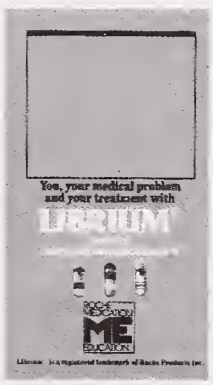
Complete the coupon and mail it to Professional Services Department, Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110.



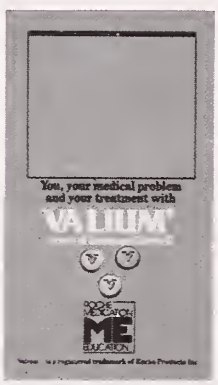
☐



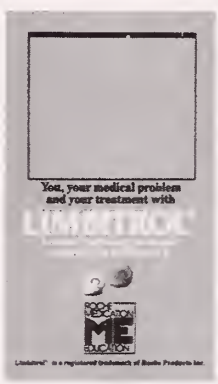
☐



☐



☐



☐

ROCHE®
Medicines that matter
from people who care

NAME

STREET ADDRESS

CITY STATE ZIP

ROCHE MEDICATION ME EDUCATION

We Wrote the Books on Patient Medication Education...

You, your medical problem and your treatment with

DALMANE®

brand of flurazepam HCl/Roche



You, your medical problem and your treatment with

LIBRIUM®

brand of chlordiazepoxide HCl/Roche



You, your medical problem and your treatment with

BACTRIM™

brand of trimethoprim and sulfamethoxazole/Roche



You, your medical problem and your treatment with

VALIUM®

brand of diazepam/Roche



You, your medical problem and your treatment with

LIMBITROL®

brand of chlordiazepoxide and amitriptyline HCl/Roche



COLLEGE OF PHYSICIANS OF PHILADELPHIA
COLL. OF PHYS. OF PHILADELPHIA
SERIALS DEPARTMENT
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103
COLL83 OCO

ROCHE

Copyright © 1986 by Hoffmann-La Roche Inc. and Roche Products Inc. All rights reserved.

To order a complimentary supply of Roche Product Books, please see preceding page.

STACKS

THE JOURNAL OF THE
FLORIDA MEDICAL
ASSOCIATION, INC. DECEMBER 1986, Vol. 73, No. 12

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
M.D.S.
FEB 19 1987

PROCEEDINGS ISSUE

PEACE



Select Quality!

The chart on this page can be used to compare the advantages of insuring with Florida Physicians Insurance Company. All medical professional liability insurance coverage is NOT the same!

QUESTION	FPIC	PPTF	ST. PAUL
Are your carrier's premiums non-assessable ?	YES	NO	YES
Is your carrier medical association sponsored ?	YES	NO	NO
Is your carrier Florida owned and operated ?	YES	YES	NO
Is the majority of your carrier's Board of Directors made up of physician's ?	YES	YES	NO

For more information call Ron Gladman:

FPIC FLORIDA PHYSICIANS INSURANCE COMPANY

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

Motrin® 800 mg TABLETS
ibuprofen



Extra strength
Convenience
Economy

Upjohn 100 A Century of Caring 1886·1986

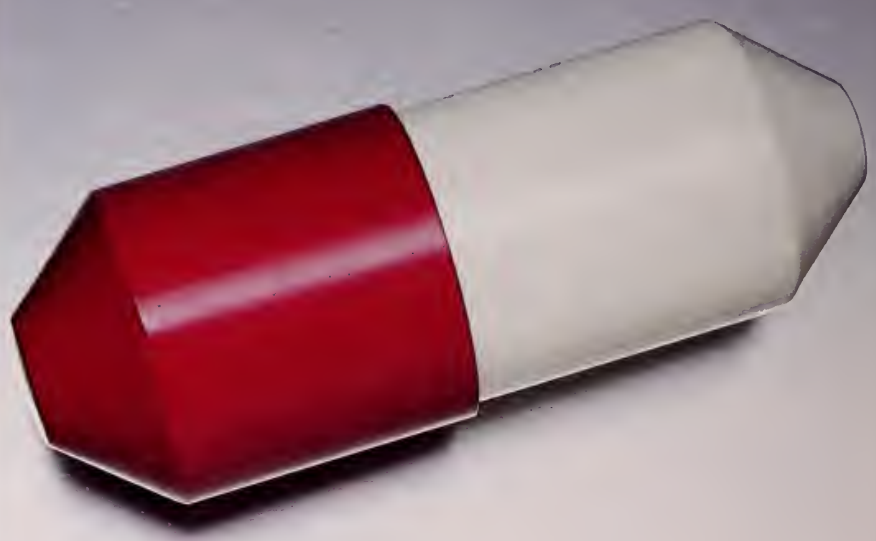
©1986 The Upjohn Company

J-6138 January 1986

In Hypertension*... When You Need to Conserve K+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L42

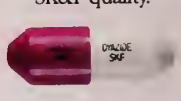
Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 20 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.



a product of

SK&F CO.

Carolina, P.R. 00630

©SK&F Co., 1983

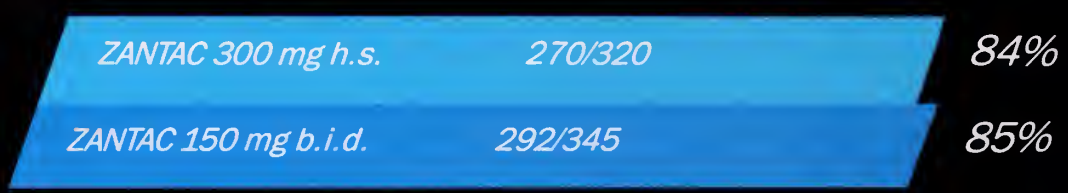
CONTROL ACID RAIN

with once-a-night h.s. therapy for active duodenal ulcers

Only one tablet at bedtime

Controls nocturnal acid to relieve pain and heal duodenal ulcers

Heals active duodenal ulcers after 4 weeks in most patients*[1]



In well-controlled, double-blind, multicenter trials, ZANTAC 300 mg h.s. healed active duodenal ulcers in 84% of patients after 4 weeks. After 8 weeks, healing rates may be higher with ZANTAC 150 mg b.i.d. (92%) than with ZANTAC 300 mg h.s. (87%).

Relieves pain and other symptoms as effectively as ZANTAC 150 mg b.i.d.[1]

Zantac® 300

ranitidine HCl/Glaxo 300 mg tablets

Once-daily dosing may enhance compliance in patients for whom dosing convenience is important

Side-effects profile comparable to ZANTAC 150 mg b.i.d.[1-3]

Headache—sometimes severe—has been reported. Rare effects on the CNS, cardiovascular, GI, hepatic, and integumental systems have been observed, as well as rare cases of hypersensitivity reactions. See ADVERSE REACTIONS section of Brief Summary of Product Information before prescribing.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 300 mg h.s. had no significant drug interactions with theophylline or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications which decrease gastric acidity are administered.



*It is not known exactly how much acid inhibition is needed to heal ulcers.

Glaxo / ROCHE

See next page for references and Brief Summary of Product Information.

IN ACTIVE DUODENAL ULCERS

Once-a-night h.s. therapy controls acid rain

Zantac 300
ranitidine HCl/Glaxo 300 mg tablets

References: 1. Data available on request, Glaxo Inc. **2.** Ireland A, Colin-Jones DG, Gear P, et al. Ranitidine 150 mg twice daily vs 300 mg nightly in treatment of duodenal ulcers. *Lancet* 1984;2:274-275. **3.** Colin-Jones DG, Ireland A, Gear P, et al. Reducing overnight secretion of acid to heal duodenal ulcers. *Am J Med* 1984; 77 (suppl 5B):116-122.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

See complete product information before prescribing. The following is a brief summary.

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy. 2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function. Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: *Teratogenic Effects: Pregnancy Category B:* Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC® 150-mg doses more frequently. Dose should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

See full prescribing information for dosage adjustment for patients with impaired renal function.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

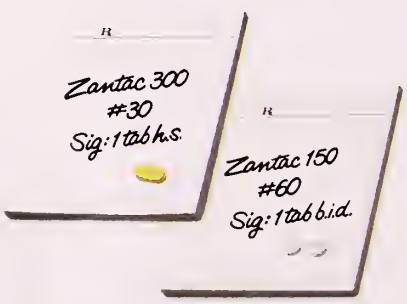
ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

© Copyright 1983, Glaxo Inc. All rights reserved. June 1986

Glaxo
Glaxo Inc.
Research Triangle Park, NC 27709

Two effective regimens to treat active duodenal ulcers:



University Physician

University of Florida

The Student Health Service at the University of Florida currently has two physician positions available. Candidates must possess a medical degree from a recognized medical college, be licensed to practice medicine in Florida, have completed one year of internship, in addition to two years of residency in a recognized specialty or have four years of general practice experience. Board certification preferred in Family Practice, Internal Medicine or Pediatrics. The candidate must also possess the ability to relate and work with a college age population. Salary minimum $45,000 and competitive depending on qualifications and experience. Excellent fringe benefits. Malpractice Insurance coverage provided. University policy is to conduct all searches in the open, subject to the provisions of existing law.

Send a complete resume by February 6th, 1987 to Henry D. Zunker, Employment Manager, 4th Floor Stadium, University of Florida, Gainesville, Florida 32611.

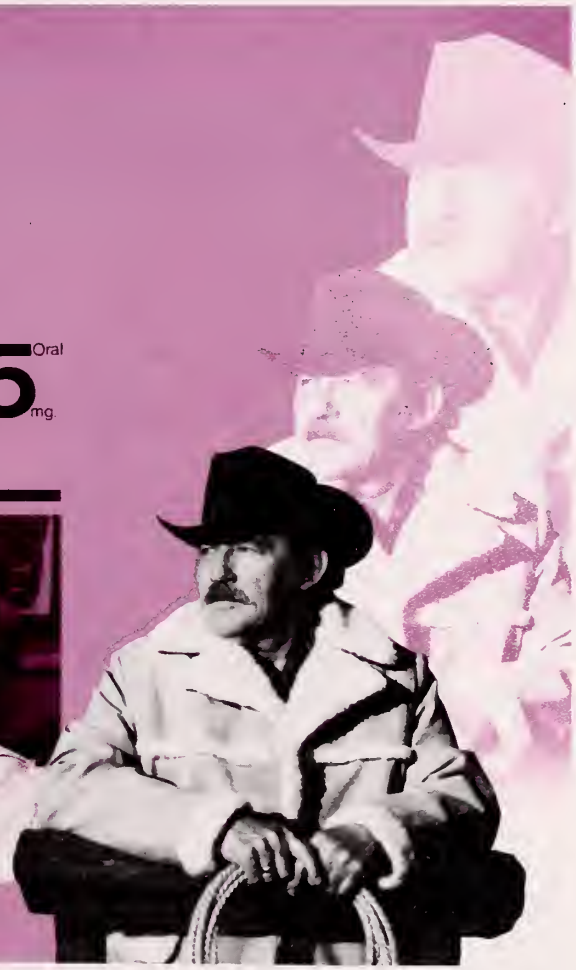
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg

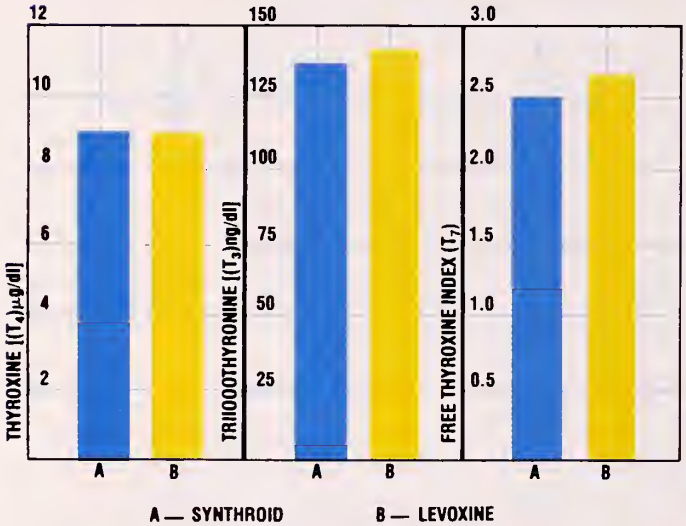




Levoxine™
[Levothyroxine Sodium Tablets, USP]



Finally, a bioequivalent replacement for Synthroid® that's reasonably priced.



Introducing Levoxine from Daniels Pharmaceuticals — a breakthrough in quality manufactured Levothyroxine Sodium Tablets, USP, now available at reasonable costs.

Randomized, crossover studies were conducted in hypothyroid subjects to evaluate the bioequivalency of Daniels' Levoxine tablets to Flint's Synthroid tablets. Serum levels showed no significant difference in thyroxine (T_4), triiodothyronine (T_3) or free thyroxine index (T_7).

Levoxine is available in nine color-coded tablet strengths. This assures prescription compliance and patient acceptance. Each dosage endures extensive quality control measures that exceed required USP testing. Thus, the quality standards are the highest possible. So when you prescribe Levoxine, you know you're prescribing just what your patients need — at a price that's more affordable.

For additional product or ordering information, contact Bernard Wolfson, Ph.D., Daniels Pharmaceuticals. Call toll free: 1-800-331-4831.

dp DANIELS PHARMACEUTICALS, INC.
2527 25th Avenue North · St. Petersburg, Florida 33713-3999



25 mcg 0.025 mg | 50 mcg 0.05 mg | 75 mcg 0.075 mg | 100 mcg 0.1 mg | 125 mcg 0.125 mg | 150 mcg 0.15 mg | 175 mcg 0.175 mg | 200 mcg 0.2 mg | 300 mcg 0.3 mg

*Synthroid is a registered trademark of Flint Laboratories.

Bioequivalency data on file, Daniels Pharmaceuticals, Inc.

Please see next page for full prescribing information

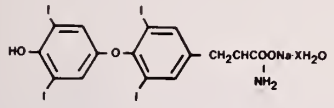
LEVOXINE™

(LEVOTHYROXINE SODIUM TABLETS, USP)

FOR ORAL ADMINISTRATION

DESCRIPTION:

Each LEVOXINE (Levothyroxine Sodium, USP) tablet contains synthetic crystalline levothyroxine sodium (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland. Chemically, L-thyroxine is designated as L-Tyrosine, O-(4-hydroxy-3, 5-diiodophenyl) - 3,5-diiodo-, monosodium salt, hydrate. The molecular formula is $C_{15}H_{10}I_4N$ Na O_4 and the structural formula is:



CLINICAL PHARMACOLOGY:

The principal effect of thyroid hormones is to increase the metabolic rate of body tissues.

The thyroid hormones are also concerned with growth and development of tissues in the young.

The major thyroid hormones are L-thyroxine (T_4) and L-triiodothyronine (T_3). The amounts of T_4 and T_3 released from the normally functioning thyroid gland are regulated by the amount of thyrotropin (TSH) secreted from the anterior pituitary gland. T_4 is the major component of normal thyroid gland excretions and is therefore the primary determinant of normal thyroid functions. T_4 acts as a substrate for physiologic deiodination to T_3 in the peripheral tissues. The physiologic effects of thyroid hormones are mediated at the cellular level primarily by T_3.

LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

INDICATIONS AND USAGE:

LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function (e.g., cretinism, myxedema, nontoxic goiter or hypothyroidism generally, including the hypothyroid state in children, in pregnancy and in the elderly) resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

LEVOXINE (L-thyroxine) 100 mcg (0.1 mg), 200 mcg (0.2 mg) and 300 mcg (0.3 mg) tablets contain FD & C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD & C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin hypersensitivity.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.

2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.

3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.

4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.

5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBg). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone: androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBg concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBg concentrations. TBg may also be increased during infectious hepatitis. Decreases in TBg concentrations are observed in nephrosis, acromegaly, and after androgen or corticosteriod therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBg deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.

2. Medical or dietary iodine interferes with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.

3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment Of Fertility — A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (1:4,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis, and maintained for life, unless transient hypothyroidism is suspected; in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, the effects do not appear at once, the symptoms may not appear for one to three weeks after the dosage regimen is begun. The most common signs of symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremors, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4, serum T_3 and free thyroxine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Vomiting may be induced initially if further gastrointestinal absorption can reasonably be prevented and barring contraindications such as coma, convulsions, or loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment of increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period or orally, 80 to 160 mg/day, especially when no contraindications exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism as judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dosage is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted full maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 25 mcg (0.025 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is the physician's judgement of the severity of the disease and close observation of patient response which determine the rate and extent of dosage increase.

In infants and children there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage of L-thyroxine in childhood is: 0-1 years: 9 mcg/kg; 1-5 years: 6 mcg/kg; 6-10 years: 4 mcg/kg; 11-20 years: 3 mcg/kg daily.

DOSAGE FORMS AVAILABLE:

LEVOXINE (L-thyroxine) tablets are supplied as oval, color coded, potency marked tablets in 9 strengths: 25 mcg (0.025 mg) — orange, 50 mcg (0.05 mg) — white, 75 mcg (0.075 mg) — purple, 100 mcg (0.1 mg) — yellow, 125 mcg (0.125 mg) — brown, 150 mcg (0.15 mg) — blue, 17 mcg (0.175 mg) — turquoise, 200 mcg (0.2 mg) — pink and 300 mcg (0.3 mg) — green, in bottles of 100 and 1000.

dp DANIELS PHARMACEUTICALS, INC.
2527 25th Avenue North
St. Petersburg, Florida 33713-3999

PRINTED IN USA

10/86

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

DECEMBER 1986, Vol. 73, No. 12

CONTENTS

1986 PROCEEDINGS

A.H. Robins Award 932
AMA Delegation 944
Board of Governors
- Report A 993
- Report B 986
- Report C 955
- Report D 1005
- Report E 1016
- Report F 965

Certificate of Appreciation 956
Certificate of Merit 955
Committee on Impaired Physicians . . 951
Committee on
- Membership Development 949

Committee on Women Physicians . . 947
Council Reports
- Hospital Medical Staffs 1014
- Judicial 950
- Legislation 999
- Medical Economics 1011
- Medical Services 984
- Scientific Activities 991
- Specialty Medicine 992

Distinguished Layman's Award 933
Election of Officers 1020
Excellence in Medical Journalism . . . 936
FLAMPAC 952
Florida Physicians Association 954
Good Samaritan Award 956
House of Delegates
- First House 929
- Second House 941
- Third House 979

JFMA Awards 939
Malpractice Prevention Award 934
Medical Speakers Awards 933
President's Address 927
President's Inauguration
- and Reception 976

Public Relations Officer 948
Reference Committee I 991
Reference Committee II 984
Reference Committee III 944
Reference Committee IV 999
Reference Committee V 1011
Remarks of the Speaker 932
Scientific Exhibit Awards 936

COVER

This month's cover of *The Journal* is a drawing by Jacksonville artist James B. Upright. The cover illustrates the Holiday Season.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.* [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc., are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

Copyright 1986 by Florida Medical Association, Inc.

RESOLUTIONS

86A-1 Vice Speaker 971
86S-2 Nasogastric Tubes 996
86A-3 Unified Membership with the American Medical Association . . 971
86A-4 Competition in Medicine 971
86A-5 Capitation as a Payment Mechanism for Medicare 1018
86A-6 FMA Membership as a Requirement for Licensure 972
86A-7 FMA Membership in Specialty Societies 996
86A-8 Membership Requirements for FMA-Recognized Specialty Groups 996
86A-9 Labeling of Prescription Drugs 988
86A-10 Commendation for FMA 972
86A-11 County Medical Society Judicial Councils 972
86A-12 Promoting Fee-For-Service Medicine 972
86A-13 Proceedings of the House of Delegates 972
86A-14 House of Delegates Referrals 972
86A-15 Not-for-Profit Liability 1007
86A-16 Sales Tax Exemption 1008
86A-17 Physically Challenged Physicians 972
86A-18 Sample Medication 1008
86A-19 Rally in Washington, D.C. . 1008
86A-20 Contingency of Patient Compensation Law 1008
86A-21 Mediation Panels 1009
86A-22 HMO Physician Liability Insurance Coverage 1009
86A-23 Education and Licensure . . . 1009
86A-24 Licensure and Assignment . 1009
86A-25 Health Insurance Requirements 1009
86A-26 Reduced Fee School Examinations 988
86A-27 Blue Cross/Blue Shield Payments 1018
86A-28 Insurance Claim Payments . 1018
86A-29 Medicare PRO Advisory . . . 1018
86A-30 Generic Substitutions 989
86A-31 Medicare Claims Rejection . 1018
86A-32 Fiscal Note to Resolutions . . 973
86A-33 Regulatory Pain and Sleeping Medications 989
86A-34 Contingency Fees for Frivolous Lawsuits 1009
86A-35 PRO Programs 1019
86A-36 Investigation of Self Insurance Trust 973
86A-37 Relocation of FMA Headquarters 973
86A-38 Expert Witness 1010
86A-39 Medicare Toll-Free Access . 1019
86A-40 1986 Constitutional Initiatives 973
86A-41 Vaccine Related Injury Legislation 1010
86A-42 Personal Responsibility 1010
86A-43 Alternative Delivery Systems 1019
86A-44 Malpractice Coverage for Physicians Providing Indigent Care 1010
Emergency Resolution — Voluntary Drug Testing for Physicians 989
Emergency Resolution — Workers' Compensation Reimbursement Schedule 1019

DEPARTMENTS

911 President's Page
Listening to the Christmas message
James B. Perry, M.D.

915 Editorials
Where do we go from here?
R. G. Lacsamana, M.D.
A Hospice Christmas
Clyde M. Collins, M.D.
Peddling the goods
H. Frank Farmer Jr., M.D. Ph.D
The need to reform indigent care
Richard J. Feinstein, M.D.

921 Letters & Viewpoints

1031 Medical Economics
Physician contributions to indigent care
The experience of Volusia County
Jacques R. Caldwell, M.D.

1037 Notes & News

1038 Dean's Message

1039 Encores!

1043 FMA Auxiliary
Bradford County Auxilians provide comfort for nursing home residents
Mrs. Walter (Isabella) Laude

1046 Meetings

1050 Classified Advertising

1053 Index to Volume 73

1058 Index to Advertisers

1058 FMA Officers and Council Chairmen

Editor:
R.G. Lacsamana, M.D.

Associate Editors:
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors:
Francis C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D.
(from the Board of Governors)

Contributing Editors:
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.

Historical Editor:
H. Frank Farmer Jr., M.D., Ph.D.

Medical Economics Editor:
Jacques Caldwell, M.D.

Cover Editor:
Andre J. Renard, M.D.

Executive Editor:
Robert C. Fore, Ed.D.

Managing Editor:
Camille H. Crabtree

Editorial Assistant:
Mary N. Fouraker

Consulting Editorial Staff:
Karl Altenburger, M.D.
Lawrence S. Berman, M.D.
Pierre J. Bouis Jr., M.D.
Patrick G. Brady, M.D.
William T. Branch, M.D.
Elmer B. Campbell, M.D.
Ronald W. Case, M.D.
Charles Craig, M.D.
James Edgar, M.D.
Pablo Enriquez, M.D.
Avrohm Faber, M.D.
Emmett B. Ferguson, M.D.
Mark Flitter, M.D.
Roger W. Fox, M.D.
John W. Glotfelty, M.D.
William D. Gieseke, M.D.
Thomas Gocke, M.D.
Allan L. Goldman, M.D.
David Griffin, M.D.
William T. Hawkins, M.D.
James G. Henry, M.D.
F. L. Howington, M.D.
Harold L. Ishler, M.D.
Karl J. Kramer, M.D.
Donald S. Kwalick, M.D.
William H. Langhorne, M.D.
Seldon Longley, M.D.
James E. McGuigan, M.D.
Gregor Melnick, M.D.
Charles E. Moore, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
Walter E. Morris Jr., M.D.
Glenn Morrison, M.D.
Kenneth B. Olson, M.D.
John K. Petrakis, M.D.
Philip B. Phillips, M.D.
David S. Pins, M.D.
Julian A. Rickles, M.D.
Arvey I. Rogers, M.D.
Hubert J. Rosomoff, M.D.
Stephen A. Shaivitz, M.D.
Harvey A. Shub, M.D.
Leonard J. Shukovsky, M.D.
Michael P. Small, M.D.
Richard N. Snodgrass, M.D.
Kim L. Spear, M.D.
Arthur J. Starr, M.D.
Vincent G. Stenger, M.D.
John W. Stone, M.D.
Robert H. Threlkel, M.D.
Malvin Weinberger, M.D.
Albert A. Wilson, M.D.
Fredric C. Wurtzel, M.D.

ALWAYS ON CALL:

AT&T'S NEW DOCTOR'S SOLUTION ASSISTS YOU ROUND-THE-CLOCK WITH EVERYTHING FROM ACCOUNTS RECEIVABLE TO SCHEDULING.

Few doctors like to think of their practice as a business, but of course it is.

So the less you have to think about business, the more you can concentrate on medicine.

That's why AT&T tailored a complete hardware and software package specifically for the medical profession. The Doctor's Solution.

It's just one member of a whole family of Health Care Information Systems. AT&T Doctor's Solution provides total office management for single and multi-doctor practices.

Far from forcing you to change the way you run your practice, Doctor's Solution simply allows you to run it more efficiently with help like this:

Automated billing gathers all charges to each patient—including exams, tests and prescriptions—and automatically calculates a single, comprehensive bill.

Accounts receivable tracks all receivables, selects balance-forward or open-item statements, sets aging intervals, and spots delinquent accounts. All of which improve your collection rates.



Doctor's Solution software takes care of your paper work so you can take care of your patients.

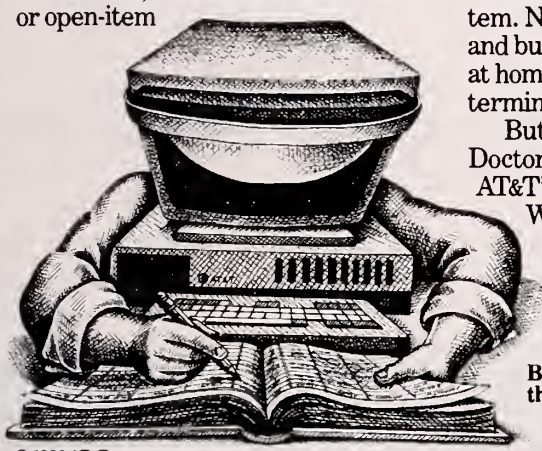
Practice management improves the flow of your practice with the ongoing maintenance of complete patient histories. Both clinical and billing information follow every patient through your office.

Patient scheduling by practice, doctor, week or month—including rounds and vacations—helps you get the most out of your time so you can give the most to your patients.

Third-party billing increases your cash flow by accommodating unlimited fee schedules and generating a variety of forms and invoices.

Remote access to your office system. Now you can get complete clinical and business information at the hospital, at home—anywhere there's a phone, a terminal or PC, and a modem.

But one of the nicest features about Doctor's Solution is that it's backed by AT&T's Small Business Connection. Which means our specialists in the medical field will make sure you get the right hardware, the right software and the right training.



By tracking who owes what, the system helps pay for itself.

As your practice grows, these specialists will help you keep your system right in step—accepting new doctors, new procedures and new diagnostics.

What's more, Doctor's Solution will work with every **UNIX™** System-based computer AT&T makes. Just one more example of "The Computers With The Future Built In."

And if you have a problem? We not only have a Service Hotline; we even do over-the-phone software diagnostics.

It's all part of AT&T's unique approach to small business. You don't just buy a system. You buy AT&T's end-to-end responsibility for that system.

And you buy it from a single source with a proven past. And a very healthy future.



Give us a call at 1 800 247-7000. We'll show you how to get your practice a lot closer to perfect.

AT&T
The right choice.

© 1986 AT&T

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

"Master Approach to Cardiovascular Problems"

FIFTEENTH ANNUAL CONFERENCE



at: The Contemporary Resort Hotel
Walt Disney World/Epcot Center — Orlando, Florida
MAY 30 TO JUNE 1, 1987

COURSE DIRECTORS: AGUSTIN CASTELLANOS, M.D. AND ROBERT J. MYERBURG, M.D.

GUEST SPEAKERS:

ADOLPH M. HUTTER, JR., M.D. — Evaluation of Patients with Chronic Coronary Artery Disease.
MASOOD AKHTAR, M.D. — Clinical Value and Cost Effectiveness of Invasive Electrophysiologic Studies.
KANU CHATTERJEE, M.B. F.R.C.P. — Current Status of Bedside Hemodynamic Monitoring.

For more information please call (305) 549-7124 or write to:
Y. BARCENA, Program Planner
Cardiology (D-39)
University of Miami School of Medicine
P.O. Box 016960, Miami, Florida 33101

Listening to the Christmas message



During the month of December one thinks of tennis matches, festivals, play-off football games and the holiday season with its joyous connotations. As a heterogenous group of care givers we are no different. There is, however, this year, a shroud that veils our celebration of this joyous season of giving and renewal. It seems that the realities of economic life of the profession have been hit exceptionally hard. Reiterating some of these may serve as a purgative.

The cost and availability of liability insurance remain a very significant soul searching problem. Some of us are paying now more than 30% of gross income for this expense alone. I dare say no other business in existence can or does afford even one half of that figure and remain solvent. The regulations of this state for mandatory insurance coverage are so impractical and then, even more onerous, regulations make the dilemma even worse. Federal contracts covering the reimbursement of care for their administered programs effectively stifle any possibility of pass-on to consumers the cost of doing this medical business. The limitation of licensure in some states under the doctrine of mandatory acceptance of assignment as a condition of practicing would seem to preclude any redress if the temerity or gall to complain is entertained. This will be discussed in Florida during the coming legislative session and is a doctrine that is being addressed by the Massachusetts Supreme Court. It could become a standard of care throughout the country in the next few years.

In still another dilemma the proprietary-for-profit clinics have seen fit to attempt networking of their operation and chosen the sunbelt states, especially Florida, to milk the cream of the affluent ill off the top of a relatively lean available patient population. The maintenance organizations and preferred provider groups further delete any semblance of a base of medical patients. A quality of care of these groups leads us to wonder if there is any possibility that the population served by these necessary entrepreneurial organizations will be objectively and honestly served. However, having had contact with a number of the physicians employed by them, a casual observation would seem to indicate that the doctors do practice excellent medicine and the altruism and ethics of their calling supercede and outweigh occasionally implemented cross policies of expediency.

Having reflected upon our problem brings me to the realization of some of the cares the holiday season would seem to engender. On our small planet there are and always will be the haves and have nots. Travelling in the Near East and Third World, one cannot help but realize the huge percentage of our planet falls into the latter category. Regardless of persuasion, many hundreds of years ago the poorest of people were, according to Scripture and belief, blessed with a Savior. Kings and princes bowed to him and in due course he grew and was crucified at a young age.

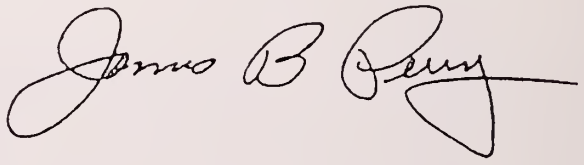
When placed in perspective, the philosophy and subsequent gifts bestowed upon mankind by the miracles and mysteries alleged to have occurred at that time by one person have affected civilization to the extent it would never be the same as long as this planet exists. We are at this time, in this century, doing what we do, particularly because of those events that lasted a mere 33 years. In the last several months I

have heard tales of woe and have commiserated with our membership on a number of issues, feeling sorry for them and our organization, and yet is this realistic? Yes, in the context of December 1986 it is proper and necessary and also important — important to seek solutions and to work toward resolution of our problems.

As you know in the last ten years and especially now these are not easy times. Our personal professional persuasions are not necessarily the realities of life nor the wishes of many people with whom we live and interact on a daily basis. When the blink of the archeological eye is considered our problems do not even exist. Yet today there are those, our indigent population, the have nots, whose lives we can influence in our own small way to, perhaps, help just a bit. It is estimated that this is approximately 2.5 million of our state's 9 million or so people. This year we as an association are in the process of working with and reacting with other leaders in attempting to bring the expertise of our profession to the disadvantaged, to offer them help and succor in their illness and plight. While this is only a small part of their problem it is a necessary step in helping them attain their goals of human dignity and a potential for fulfillment.

We will not be alone. There will be taxes levied on all citizens, even those who receive the care. The local health departments, every physician and every treating facility will be a care giver and involved and, yes, because the care givers are at risk and because the people are receiving and are paying for this care there will be a modified sovereign immunity (see November President's Page).

The important concept is that we in an affluent society will take example and heed the message of that Man who taught us the way thousands of years ago. Perhaps in hearing and listening to Him and reacting in a responsible way, our problems will be our strength and not our weakness. Truly a motto to live, not just speak, is peace on earth, good will toward men.



GOING BARE?
SELF INSURED?



New Florida law gives health care providers malpractice insurance options never before available.

First Defense can now offer low cost legal defense insurance which makes "going bare" or being "self-insured" a practical alternative to malpractice insurance.

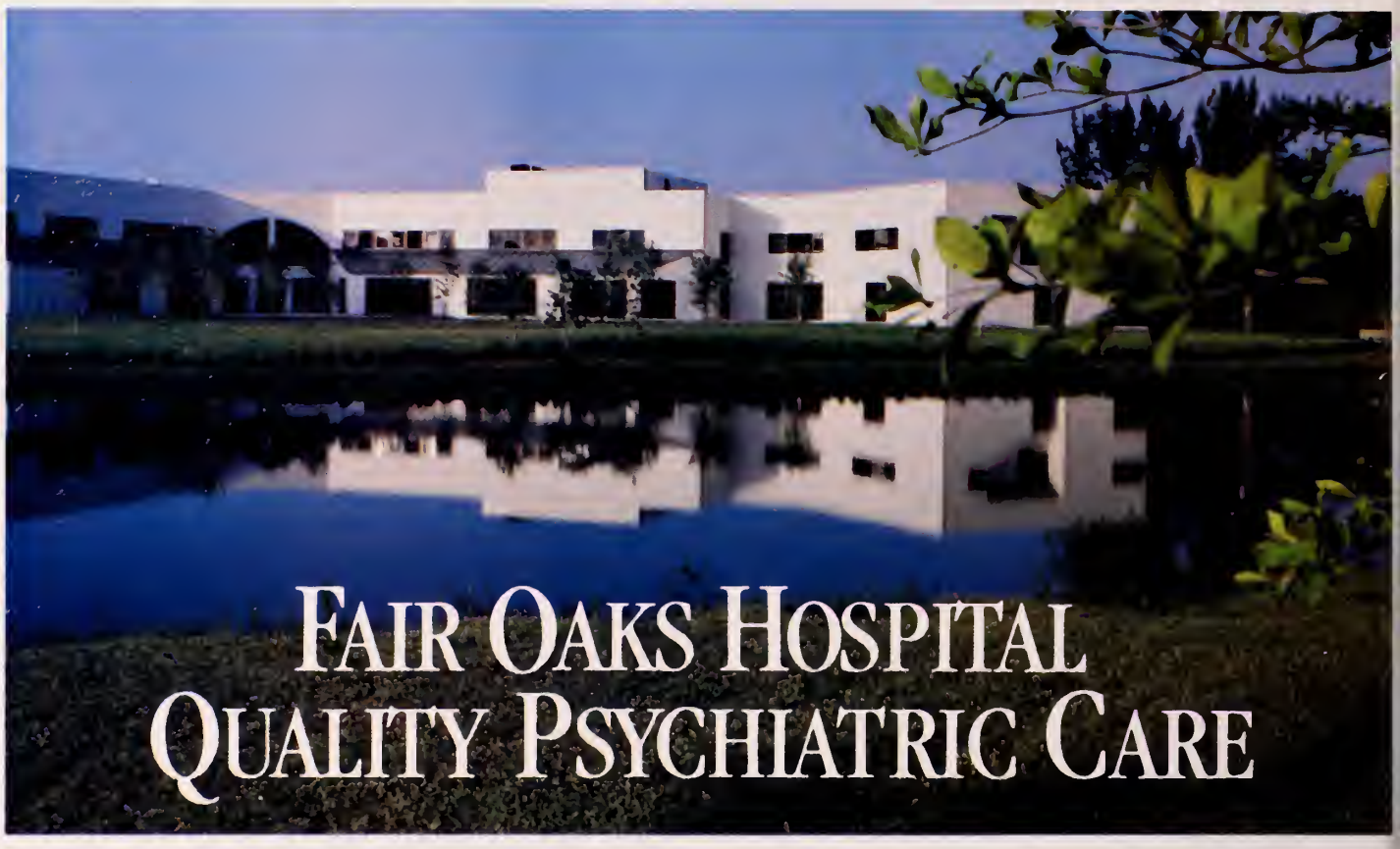
High limit standard malpractice insurance should be your first choice. However, many professionals aren't able to afford such coverage. If you have decided not to purchase standard medical malpractice coverage, you still need your assets and license to practice protected. First Defense is the only licensed insurance corporation in the State of Florida that can provide legal defense insurance of this kind.

Special DPR coverage to handle all legal costs and attorneys fees of the Department of Professional Regulation investigation and prosecutions is also available for $250.00 a year.

Call or write First Defense Legal Services Insurance Corporation, 1350 Southwest 57 Avenue, Suite 208, Miami, Florida 33144 - Telephone (305) 264-8722.

First Defense
Legal Services Insurance Corp.

1350 S.W. 57th Ave., Suite 208, Miami, Fl. 33144 - Ph. (305) 264-8722



FAIR OAKS HOSPITAL
QUALITY PSYCHIATRIC CARE

Fair Oaks Hospital at Boca/Delray is a psychiatric facility that values the judgment of the referring physician. Our specialty programs are led by full-time Yale-trained psychiatrists who value and utilize the medical model.

As the referring physician, you have the opportunity to collaborate closely with our staff physicians during all phases of evaluation and treatment.

A thorough patient evaluation is conducted on the Neuropsychiatric Evaluation Unit before treatment is administered. Thorough medical, neurological and neuroendocrine testing is performed, in addition to psychological and family assessments. Individualized treatment plans are carried out by our multidisciplinary treatment teams on our Adult Psychiatric Unit, Addiction Unit and Adolescent Hospital.

The Addiction program specializes in cocaine abuse and has pioneered in new treatments for the cocaine abuser.



Fair Oaks also has a unique reference source . . . cocaine addicts themselves.



Serving as the local sponsor for the **1-800-COCAINE** National Helpline for Florida callers, we have a direct link to drug users. Fair Oaks is able to apply Helpline information in the development of treatment and research programs.

The Adolescent Hospital is under the direction of a full-time board certified child and adolescent psychiatrist and includes a full-time school program. Specialized tracks exist for adolescent patients with psychiatric and substance abuse problems. Admissions counselors are available 24 hours a day to discuss all details concerning the hospital.

For more information call or write:

Admissions Coordinator
Fair Oaks Hospital at Boca/Delray
5440 Linton Boulevard — 305/495-3737
Delray Beach, FL 33445 — 305/495-1000

FAIR OAKS
HOSPITAL
AT BOCA/DELRAY

Where do we go from here?

The end of the Medicare freeze this month normally should be an occasion for physicians to rejoice after three years of mandated fee restrictions. But most physicians are not celebrating. In fact, a lot of them are mad and frustrated. They are mad at the idea that the allowable fee increases are miniscule compared to their soaring overhead expenses, and frustrated at the fact that what should be a simple matter of calculating a fee increase is turning out to be the most complex puzzle devised since the invention of the Rubik Cube. To add to their frustrations, physicians will have to decide one more time on whether to participate or not in the Medicare assignment program, a move clearly designed to bludgeon some physicians to their knees and to divide the medical community in the process.

The Medicare dilemma in a sense is a symbol of the larger problems and issues facing the medical profession the past few years. For those on the outside, it is easy to be smug and to dismiss these changes as part of a normal evolutionary process in the practice of medicine. But the changes are quite revolutionary, threatening to change the face of medicine from a humanitarian profession into an impersonal, competitive and highly commercialized trade, with physicians playing the bit roles, and assorted third parties in control of the profession. The latest AMA survey among physicians found 56% of them saying that they have been losing control over their ability to make decisions on patient care.

Physicians confronting these developments in their profession must feel overwhelmed by the immensity of the changes and the ordeal of having to face a future that looks bleak from any perspective. The never-ending professional liability problem, for one thing, continues to torment physicians with recent 30% to 35% premium increases even as the Coalition for Tort Reform forced passage of a few proposals in the last legislative session. Government regulations are coming down in frenzied torrents, drowning the profession in useless paperwork, hamstringing physicians in taking care of patients, and diluting the quality of patient care. At the backdoor, big corporations and insurance companies are sneaking in to corner the medical marketplace, with physicians again being lost in the shuffle. And as competition heats up, the number of physicians continues without let-up, bringing joy to those who feel that more doctors will mean less medical expenses, and woe to those who discover that life after medical school and residency training can be a jungle with limited opportunities. The list goes on and on, leaving physicians perplexed.

What should we do and where do we go from here to survive these threats and challenges to our profession? The easier thing is to do nothing, to be complacent about the situation, and to accept the notion that things are what they are because we are powerless and have been powerless to do anything anyhow. A big number of physicians unfortunately fall into this thinking trap, accepting the inevitability of what is happening, and citing the inability of organized medicine (meaning the AMA, state medical societies, and other medical organizations) to influence the course of events towards physicians. But there are obvious fallacies in this thinking.

To do nothing is surely the quickest way to destroy the medical profession; there are vultures waiting in the wings for such an opportunity and they will come swooping down to have a feast at our expense. The examples of Great Britain, Canada, and Sweden should be a reminder to those who think this way that socialized medicine is just around the corner waiting to be tapped into our system. To accept the

inevitable, on the other hand, is to be ignorant of the political process and to assume that our politicians will screw it up anyway no matter what we tell them to do for us. Paranoia about politicians is perhaps a reality; it should not blind us, however, to the possibility of changing things favorably for our own profession and for the patients whom we represent. Just as big a mistake is to imply that organized medicine is impotent and incapable of averting the changes taking place today. Organized medicine has represented physicians, whether they belong to the AMA or not, in every arena, in every debate, year in and year out, and while it has not won every battle, it has championed the interests of physicians and patients without fail. Those who subscribe to the thinking that AMA is impotent are, unfailingly, those who have never participated in the activities of organized medicine.

There is a better way than just to sit idly by and wait for things to happen, and that is to continue to fight, harder than ever, for the cause of medicine. That sounds empty and hollow in the context of what is happening, but it should not be that way. Most of us entered medicine fired by lofty ideals and an unflinching dedication to serve others; while the political and social climate may have changed, and while the economic rewards of medical practice may not be as bountiful, we must be vigilant as ever in preserving those things that have stood our profession so well the past many years. Maintaining the quality of care, guarding the sanctity of the patient-physician relationship, preserving the freedom of physicians to practice, fighting third-party intrusion into medicine, and reforming the tort system — these are some of the things that we ought to be vigorously pursuing, whether by political action, public education, or some other means. At stake here is the continued survival of a health care system that has been called the finest ever devised in the world. We can lose it by default, or we can still bequeath it to future generations of physicians.

R. G. Lacsamana, M.D.
Editor

A Hospice Christmas

The chart gave his age as 35, but David looked more like a 22-year-old blonde college student. On closer inspection, however, his hair was thin from completing his last chemotherapy. X-ray reports on the chart mentioned a widened mediastinum and pleural fluid plus an operative report of a mediastinoscopy and biopsy reported as undifferentiated carcinoma. Now further aggressive therapy seemed not to be in his best interest and, referred to the Hospice program with a life expectancy of three to four weeks, he was being cared for at home. He was admitted to the inpatient unit on December 2, 1986 for pain-control as the misery in his left chest and back was becoming unbearable in spite of taking 120 mg. morphine every four hours. He was frightened because two days previously he had noticed some numbness in both legs and now was unable to bear weight on his left leg. Pessimistically, he told his wife that he too thought he would not live to see Christmas.

Mentally very alert, he talked of leaving his home in Maine 15 years ago to come to Florida looking for work. He got a job in a nearby small town at a service station, and during his first week a pretty girl drove up to buy some gas. He was so impressed that he told her on the spot that some day she would be his wife. She told him he must be drunk for she was going to school and planned to graduate. Her parents were very opposed to their daughter being courted by this brash young Yankee but less than a year later they were married, and he eventually went to work for his father-in-law. Soon they had two children, a boy and a girl. Unfortunately, the girl had cerebral palsy but this did not prevent the patient and his wife from loving the child dearly and attempting to provide opportunities so that she could lead as normal a life as possible. They were very happy until three months ago when he developed a hacking cough followed by severe chest pain. His family doctor referred him to a cardiologist who referred him to a chest surgeon and after the biopsy to the oncologist who had recommended Hospice.

He did not smile, and often took a long time to ask questions or give an answer. "Give it to me straight, Doc," he said, "how long do I have to live?" I told him, "I cannot give you a definite time but you probably will not die before Christmas for the human body is a miraculous machine. If you can take some nourishment daily, can maintain a pain-free state and have something really important to live for, the body's defense mechanisms are strengthened by this will to live." He did not say anything but the way he held on to my hand made me think, "Maybe he will not give up."

The next day, much more comfortable, after having two other drugs added to his regimen, he was all smiles and cheerfully wanted to know when he could go home. Standing at the foot of his bed I joked with him, while his mother on one side of the bed and his wife on the other side alternately laughed and wiped tears from their eyes as he told of the many happy times during their married days and realistically planned his life at home for the remaining days.

As of this writing, a few days later, reports from the visiting RN, seeing him at home, are that he is

eating fairly well, sleeping better, but that the pains recur at times and the paralysis is progressing.

What is the message and why is this sad sequence of events so heartwarming at this time of the year? Is it that this is a time when on the airwaves over and over can be heard the refrain, "I'll be home for Christmas?" No, I think it is because of a brave, young father going through a time of self-evaluation and frightful fear of the future, planning how he will relate to his children, his wife and to his God by showing his true spiritual and moral fiber. Realizing that, in years to come, could he look into the eyes of his children, and of generations yet to come, he will be there, for immortality lies not in material things one leaves behind; but in those one's life has touched, by a shining festival of unselfish love, expressing a system of family values, moral absolutes, fixed truths or a meaning of man's purpose here on earth.

Clyde M. Collins, M.D.
Medical Director
Methodist Hospice
Contributing Editor
Jacksonville

Peddling the goods

I recently had an opportunity to renew a friendship with one of my former history professors, a man of insight, a keen observer of the American scene and a chronicler of various aspects of cultural and social history. During the course of our conversation in which we were discussing medicine and its role in American society, I was somewhat surprised when he asked what I thought of the attempts of various hospitals to entice patients into their environs with radio jingles, T.V. ditties, etc. To my former teacher, some of the methods being used to entice "new meat" into the hospitals were downright degrading as he saw it. I was somewhat shaken by this, not only because of the implication that the world of medicine seemed to border on hucksterism, but because a learned man was concerned about this. It also was clear in the course of our conversation that this was perceived as a change from the more dignified, professional approach that existed previously. My friend stated that, of course, the problem was clear — too many hospitals and not enough patients.

Upon pondering these remarks I found no solace that he was referring to hospitals and we physicians had escaped this turn of events. I knew that the same thing was occurring among physicians with ads promising transportation to the nearest outpatient surgical facilities, no out of pocket expenses (over and above Medicare and impending additional insurance coverage to cover that amount) and full-page newspaper layouts depicting the wonderful results of a particular surgical technique or medical treatment. No, unfortunately, physicians have to be included.

I think that what bothered this intelligent man, who knows very well the trials and tribulations of medicine over the past century, is that some in the medical profession seem to be trying to erase years of struggling to gain a professional status and a favorable position with society and to resort to a turn of the century mentality with unbridled gimmickry, charlantanism, and outright dishonesty. He is well read in American culture of the late nineteenth and early twentieth century when so-called "physicians" roamed the countryside with their snake oil, incantations and extravagant claims. These physicians were unlicensed, unbridled and uncontrolled. Hospitals were, in part, death houses where the poor and infected were sent to die segregated from the rest of society.

What happened between that time and the present is a time of struggling to root out the incompetent, establish medical education on a scientific basis, inaugurate licensing procedures and strive to erase the memory of this period of medical care. Hospitals went the same process, albeit, somewhat later with the transition of the modern hospitals with high technology not coming into full bloom until after World War II.

Both physicians and hospitals were able to overcome their past reputation and public suspicion to become respected entities and provide competent, professional services to the sick and injured. Now, it seems that we are trying to practice self-mutilation and actively pursue a course that threatens to lose most of that respect so doggedly earned. I realize that my position is a two-edged sword as the changing medical scene with DRGs, HMOs, reduced hospital admissions and empty hospital beds have compelled physicians and hospitals to embark on new approaches which include innovative ideas and aggressive marketing. Aggressive marketing, I suppose, includes advertising. But, there is advertising and there is advertising. Attempts to beckon the public in with gaudy ads that resemble red-light districts in our metropolitan areas have to be distinguished from efforts to highlight, in a nonoffensive way, new programs which will better medicine and provide new avenues of treatment for patients.

What my former professor was saying in essence is that he cannot understand how a profession that had to battle for its place in the sun for the last 85 years is now rushing pell-mell down a path that is bound to blemish its reputation, soil its veneer and recall a sordid past.

These reflections were told to me by a friend of medicine who has no animosity in his heart for the medical profession, but whose readings on American society has led him to appreciate the difficulty and long struggles which medicine went through to become a respected profession. Now, through short-sighted actions of some physicians and hospitals, that

status is threatened, at least in the eyes of some. His thoughts were an expression of regret and sorrow, tinged with some exacerbation that medicine would come to this.

I would like to assure my former mentor that what is happening is an aberration, a temporary adjustment caused by sudden changes in medical economics and approaches to medical care and only represents a temporary phenomenon. I suppose that I could take a pessimistic view and say that I would like to give assurances but cannot in view of the circumstances. However, I think my friend feels that medicine will survive this period in its history as it usually has. He is too keen an observer of American history to believe that this type of approach will last.

Moreover, while he and I and most physicians know that while advertising is legal and restraint of advertising is illegal, there is no law against strongly expressing an individual opinion to obnoxious or distateful approaches. There is nothing to say that physicians have to stand idly by like muted gargoyles while members of our profession hawk their wares in a manner reminiscent of patent medicine peddlers of yesteryear.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor
New Smyrna Beach

Special thanks to Charles E. Wynes, Professor of History, University of Georgia, whose remarks led to this editorial.

The need to reform indigent care

Health problems of the poor are often compounded by their poverty and ignorance. They lack proper nutrition, a clean and safe domicile, and an understanding of how environmental and social factors influence illness and wellness, but even when they do, few possess the ability to escape from the vicious spiral of poverty and failure.

It became quite obvious to me during my internship at a large public hospital in Washington, D.C. that many health problems are created by illiteracy, poverty, familial violence, and other factors that could not be corrected even by the accessibility of qualified physicians and hospitals with convenient operating hours.

Poor people, in addition to everything else, have no economic and political power and they are ignored by society and by its democratically elected representatives because they rarely vote or make contributions to political campaigns. Public officials are not beholden to the poor except for election year rhetoric when it is good form for some candidates to express a public willingness to care for the poor if elected, although they rarely do so.

Such rhetoric is not new. I was a medical student in 1965 when Medicaid was implemented by Congress and heralded as the guarantor of equal health care for the poor, yet Congress hedged, as it often does when it is forced to put its money where its mouth is, and it voted to share financial responsibility with the states. Some states never voted to even participate in Medicaid, while others like Florida contribute so little as to have made the system a farcical failure.

Like other physicians who have treated Medicaid patients, I have received many Explanation-of-Benefits notices from Florida's Medicaid intermediary, EDS Services, detailing my charges for five or six patients, along with a check made out to me for ten or fifteen cents. This check has always arrived only after months of repeated inquiries and accusations by EDS clerks about the insurance claim form, which was almost always filled out properly by my staff, and almost never handled properly by the EDS staff. Their fee for processing my claim forms must certainly exceed by ten fold my payment for having provided medical care to the patient.

It is never surprising to me in an election year to hear certain politicans, like Rep. Mike Abrams (D-Dade), publicly attack physicians for an unwillingness to accept Medicaid assignment. He recently quoted a survey that I had not heard of before, which found the major reason why physicians do not accept Medicaid patients is their abhorrence of having poor people cluttering up their offices. I do not believe that study at all and I do not see Medicaid patients because Medicaid in Florida is the most inefficient bureaucracy that I have ever dealt with, and because it does not pay me well for my services. I prefer to treat Medicaid patients for free and not bill EDS. This provides a charitable service to these patients while denying EDS the 56% matching funds that the Federal government is obligated to pay for its miserable bureaucratic inefficiency.

Congress also hedged when creating Medicare, requiring patients, few of whom have been educated as to how the system works, to purchase co-insurance from a variety of potentially unscrupulous companies for the 20% that is not covered. Congress should have provided coverage for the entire amount and raised premiums to offset the difference. They should also have created a catastrophic risk pool, for a small additional premium, as Secretary of HHS Otis Bowen, a physician, is now planning to do.

Neither Congress nor our state government has done anything to teach people how to stay healthy. They praise and fund HMOs for their preventive efforts while these HMOs do little more than publish self-laudatory periodicals which serve only to entice more of the unsuspecting elderly to sign away their rights from competent fee-for-service medical care.

The government also does little or nothing to improve housing, nutrition, and other preventive measures, instead encouraging the sale of alcohol, tobacco, firearms and other destructive tools by failing to levy adequate excise taxes to discourage their use and pay for the health and social problems that these vices create.

They have failed because politicians are unwilling to attack the lobbies that support these vices and their campaigns, choosing instead to give lip service to the needs of the poor, while attacking the medical profession as the source of the health care failures of their administration.

About 35 million Americans have no health insurance and an additional 35 million have inadequate insurance, and many people believe that physicians are behind a nefarious plot to maintain this status quo. Why in heaven's name should physicians oppose health insurance for all Americans when the average physician provided $18,000 of uncompensated medical care in 1984?

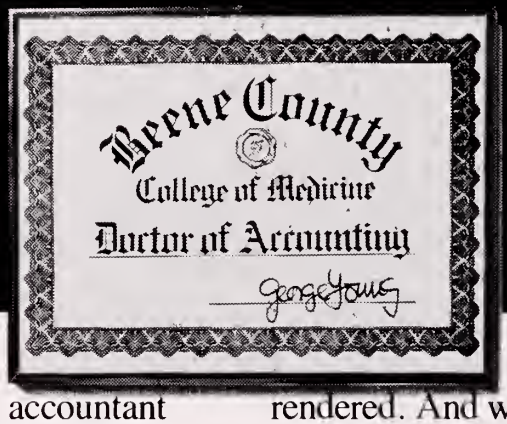
We should encourage Congress to do away with the deductible for Medicare and to provide catastrophic coverage for a small additional premium to all beneficiaries. It should assume full responsibility for Medicaid, and pay reasonable physician and hospital fees so that poor people can really obtain high quality health care at the same facilities as other paying patients. Why should poor patients in New York receive better care than those in Florida just because their state is willing to subsidize better health care and our state is not, and why should Medicaid patients have to go to Medicaid mills or the few widely scattered public facilities? When Medicaid is administered as efficiently as private insurance, I doubt if Rep. Abrams will find any physician turning Medicaid patients away, no matter how they look or how they dress.

Physicians should seriously consider the consequences of failing to lobby for health insurance coverage for all Americans. One small augury of things to come was Rep. Abrams' proposed legislation to levy a special tax of $500 per year on physicians to help support the bankrupt and inefficient Medicaid system in this state. This legislation was defeated in the 1986 session, but may surface again next year. Florida already taxes hospitals 1.5% of their gross revenues for indigent care, and physicians are the next target. It seems absurd that physicians, who work hard every day caring for their patients and who almost universally provide uncompensated patient care, will be selectively taxed to pay for the care of the poor. There are also plans to levy a 5% sales tax on physicians fees. Many patients and all insurance companies will refuse to reimburse doctors for this surcharge, and the sales tax will really be a poorly disguised attempt to discriminately tax physicians to fill the state treasury for the Legislature to use as it sees fit. How many other occupational groups do as much for society as medical doctors?

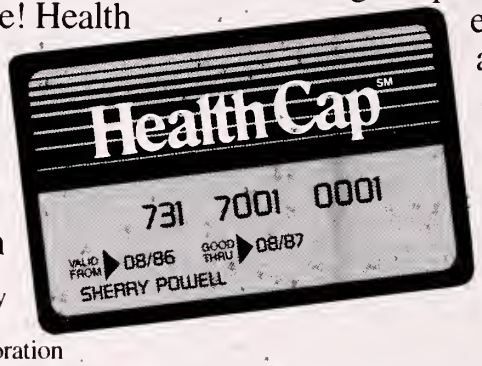
Legislators have always been afraid to deal seriously with the social, educational and health problems of the poor. They are afraid to antagonize the politically active by raising taxes and some now look upon the medical profession as a weak and easy target for a much publicized attempt to place a Band-Aid over the gaping wound of the neglected poor.

Richard J. Feinstein, M.D.
Contributing Editor
Miami

Your money or your life!



You can continue moonlighting as an accountant — involved in monthly billing, collections and credit problems — or spend your life as intended: practicing medicine! Health Cap's[SM] the hands-down choice! Our credit card system automatically deposits your fees in full, up front, on the day services are rendered. And with a separate line of credit used only for health care, your patients can afford — without hardship — regular preventive treatment and elective procedures. Were all those years of study and dedication geared to chasing down accounts receivable? With Health Cap,[SM] your life is much more rewarding!



C&S Brought to you by Health Care ® Assistance Corporation and C&S National Bank.

Get more information today!

Call Health Cap[SM] 1-800-282-5599

The credit card for your medical and financial well-being.

Questions on chelation therapy

Your article in the September 1986 issue of the *JFMA* on Chelation Therapy by Mark R. Montgomery, Ph.D., is guilty of all the exaggerations and illogical conclusions that he associates with quackery. Dr. Montgomery proceeds with his hypothesis that low body burdens of various heavy metals are nontoxic, and forms a conclusion that chelation therapy is, therefore, quackery. He selects his observations to further substantiate this hypothesis by noting that the proponents of chelation therapy were often past supporters of Laetrile and that these people themselves use unscientific methods. He then proceeds to other observations that he claims support his hypothesis, e.g. chelation therapy must be bad because physicians who practice this treatment utilized hair analysis which occasionally is subject to errors from external environmental pollution. The article continues on to cite various facts, intermingled with conjecture, to support the preordained conclusion. Even his bibliography would leave one to believe that he is writing a paper on Laetrile or green hair, since not one of the references is concerned with chelation.

As a physician trained in the scientific method, I would truly like to hear the straight story on this therapy. I am quite surprised that *The Journal* would accept for publication a paper as unscientific as this one. I might mention that I am a board-certified ophthalmologist who, indeed, does believe in the scientific method. However, I am not so narrow-minded as to write off a new idea merely because it flies in the face of conventional wisdom.

The medical society would do us all a service perhaps by awarding a prize to a medical student who would thoroughly research the literature on this subject and present his report to the membership.

Scott L. Geller, M.D.
Ft. Myers

Author's response: Nowhere do I state the hypothesis that "low body burdens of various heavy metals are non-toxic." Rather, the unsupported premise of chelation therapy is that numerous diseases are due to low body burdens. There is a major difference. With Dr. Geller's respect for the scientific method, he will remember that, in science, the burden of proof is on the one who makes a cause-effect statement. A hallmark of quackery is to attack negative opinions without providing objective proof of the cause-effect relationship.

Nowhere do I state or suggest that proponents of chelation therapy were past supporters of Laetrile. Perhaps Dr. Geller has some independent information on this relationship. My comparison is between the characteristics of the Laetrile movement as a solution to all forms of cancer and the marketing of chelation therapy as a solution to many divers illnesses.

Hair analysis is simply not a valid clinical diagnostic tool. Readers are referred to a recent article in *JAMA* 254: 1041-1045, 1985, that leaves little to doubt. An example from ophthalmology may be appropriate: tunnel vision is one of several characteristic symptoms of alkyl mercury intoxication. I trust Dr. Geller would examine for additional characteristic symptoms and would seek blood/urine/

history/environment/occupation verification of a suspected cause-effect relationship between this one symptom and a particular metal before initiating therapy, even if a hair analysis indicated the presence of mercury in the hair (which it will).

I fully agree that an additional objective report on this subject, in addition to the basic principles that are well recognized by the scientific and medical community, would be of further value. I thank Dr. Geller for bringing his arguments before the professional community, rather than to suggest we debate each other before the lay community on a "talk show" or the equivalent.

Mark R. Montgomery, Ph.D.
Professor of Toxicology
University of South Florida
Tampa

More tales about chelation therapy

About 35 years ago, ten of us students were lined up outside a patient's room. We had orders to go in, examine the patient, make a diagnosis and report to the professor. The third student went in, stayed briefly and returned stating the patient was too sick to be examined. The gale of laughter following his pronouncement was at a peak complementary to the tenseness of the moment.

I did not laugh. Common sense of the profound truth applied was that ten examining students could have killed a very sick patient from mental aggravation. The thing (often called a lesson) learned was "do something, right or wrong, do something."

The lesson became a reality later while practicing some sort of "medicine" out here in these swamps, alone, alone without technical help and no laboratory. This was augmented by a patient load of 100 people a day, and near that most of the time. Time brought me suddenly in contact with two patients that were "too sick to treat." One had been bitten by a black widow spider and the antiserum (Latrodectus mactans) did not work. Another had been bitten by an overgrown cottonmouth moccasin some four hours earlier than 2:20 a.m. Certainly, mutiple doses of the antiserum should have helped; but he preferred, without question, to die. Both were given chelation therapy. Both were well in a few hours. The snake bite may have taken longer because he did not bother to return the next day.

I learned this from Paul Williamson, M.D., who is deceased. He once wrote a magazine called *Practice*.

Forrest Hinton, M.D.
Immokalee

Are two dead doctors enough?

November 1986 witnessed the death of the second doctor in Brevard County this year from causes other than "natural." The first was described by the newspaper as a suicide. The second one was described in juicy detail by the newspaper in several articles indicating his nude body was found in his office along with empty vials of Talwin and Versed, and that he apparently hemorrhaged fatally when he severed a major femoral vessel while attempting to cut down to it. Though the latter was not a member of this medical society, I say he was one of us.

Both of these physicians practiced in Brevard. They endured a long process of education presumably sustained by the same dream of becoming a healer that we all shared. They both left a family. They shared with us the stress of bearing great responsibility daily, the anger and confusion associated with the increasing economic and legal intrusions into our field, and most of all, they shared the loneliness. Who is there when we make decisions about life and death? Who is there when we make decisions about our own life or death? Who was there when they died?

Am I my brother's keeper? An age old question. I do not want to pry, to get involved. Everyone has a right to privacy. If he wants help he will ask for it. I am not a policeman. I am not his mother. And so it goes, on and on . . . Who better than we know how hard it is to shed our mantle of knowledge, power, independence and invulnerability to say, "I need help." What will my patients and colleagues say if they find out I have a problem with alcohol, drugs, depression, marital discord, burnout . . . ? If we are not our brother's keeper then we are both alone. Perhaps fatally alone.

The general signs of a physician getting in trouble include withdrawal from his usual activities, changes in personality, changes in dress and appearance, signs of intoxication, deterioration of performance, avoidance of friends or coworkers. When to intervene? When you care enough! How to intervene? A direct approach to a friend sometimes establishes the necessary caring contact to get that friend to appropriate help. Unfortunately, direct individual approaches frequently lead to denial and anger from the person who needs help the most. The Impaired Physicians Committee of your medical society stands ready to help. It is not a punitive committee. It is composed of members of your society who are willing to confront a physician with the evidence of his or her difficulties, to stand up to the anger and denial, and to try to help the physician get whatever help is needed. We become advocates in the effort to help retain the license of the impaired physician should D.P.R. become involved. The committee maintains the highest level of confidentiality. We have successfully

helped a number of our professional brothers and sisters.

Please care enough, and let us help. Two dead doctors are enough!

Burton Podnos, M.D.
Chairman
Impaired Physicians Committee
Brevard County Medical Society
Rockledge

More Medicare woes

After reading the letter by W. E. Manry Jr., M.D., of Lake Wales (*The Journal*, July 1986), I would like you to consider publishing the following letter that I am giving to my consultation patients in the hospital who need surgery.

To My Medicare Hospital Patients:

I was asked by your attending doctor to see you for a surgical problem. After careful evaluation through physical examination and appropriate and necessary laboratory tests and x-rays, I have determined that surgery is indicated.

For the physician and the hospital to receive reimbursement for services rendered, since your case is not a "life and death emergency," we must discharge you and allow you to return to the hospital in three weeks.

The Medicare system has become a very difficult system for the doctor and the patient to tolerate. To give you an example, I recently had a lady admitted to the hospital for a urinary tract infection and in addition, her uterus, bladder and rectum were hanging out through the vagina and extended half way down her thigh. After inserting a pessary to hold things up in the vagina, I treated the patient with some cream to clean up any infection and then took her to the operating room to remove the uterus and repair the bladder, rectum and enterocele, an operation which was successful. The patient did well. She was relieved of her pain, and now once again able to walk and perform her normal functions and care for herself, something she has not been able to do for nearly three years.

Just last week I received payment for my care. I was told by Medicare that the repair of the bladder and rectum and enterocele was an ancillary procedure and that I would not be paid for it. In addition, since I had performed the hysterectomy with the non-indicated procedures, I would only be paid $295.50. To comply with the Gramm-Rudman bill, they deducted 1% which was $2.96 on a total bill of $1,750.00. We did notify the secondary carrier for which the patient had been paying for supplemental coverage for her Medicare and they were gracious enough to send me an additional check for $5.00. You must realize that I was paid by the government for the actual operating time less than a plumber and his helper would make and who does not have to pay $79,000.00 a year for a liability insurance premium and who does not have to pay a large office staff and medical office overhead.

The second patient seen by me was a 65-year-old lady who had had vascular surgery performed on her legs. Just before her doctor was to let her go home, she reminded him that she had been bleeding for the past 15 days. I was asked to see this lady and did a biopsy from inside the uterus with the tissue being obvious cancer. I called the operating room to schedule her for a hysterectomy and removal of both tubes and ovaries to cure her cancer. The scheduling personnel recognized her name from the previous week and informed us that neither I nor the hospital would be paid for any of the surgery because the patient was admitted with another diagnosis. To get paid anything, I would have to discharge the patient and re-admit her in three weeks with her knowing that she has cancer and needing surgery.

Therefore, I want you to understand that I, as a practicing physician, would be bankrupt for accepting fees that pay me less than one-half of my overhead cost.

You must understand, therefore, that I cannot accept your Medicare as payment for your surgery. I would appreciate you signing this letter and returning it to my office to be placed in your file!

Alexander P. Rosin, M.D.
Jacksonville

Postmortem often still needed

The lack of effort on the part of practicing physicians and hospital residents and interns to obtain permission for postmortem examinations, for which unfortunately today's litigious climate may be partly responsible, is regrettable. In the event the family should initially object, one may request an examination be limited to an abdominal incision. In some instances, one may settle for permission to perform percutaneous needle biopsies of the liver, which would provide multiple specimens. Nowadays, one might even settle for a postmortem laparoscopy. When surgery has been contraindicated, a necropsy may provide the sole means of establishing a diagnosis, which can only enrich the experience of the clinician and ease the concerns of the surviving family.

Equally discouraging is the negligence on the part of some physicians to attend surgical operations on their patients, not only for their own benefit, but for

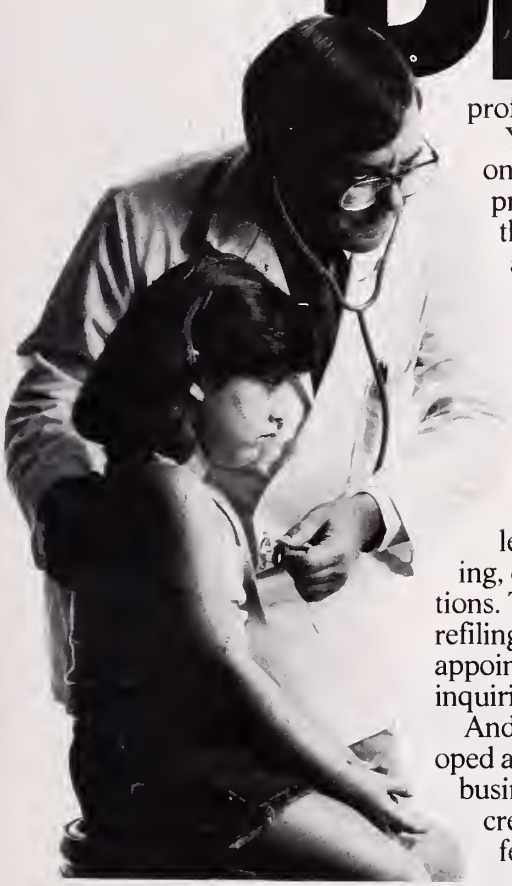
that of the family. Observing pathology in the living has no truly comparable substitute.

We are presently apt to lean too heavily on the brilliant advances in hepatobiliary imagery. In the event of a fatal outcome in a patient too ill for surgery, one may be disinclined to request permission for a necropsy because of the results of hepatobiliary imagery. Nevertheless, in spite of their great value, these procedures are fraught with pitfalls.

For example, a bile duct carcinoma may simulate sclerosing cholangitis, and an iatrogenic stricture at the junction of the right and left hepatic ducts may resemble the so-called Klatskin tumor. A blood clot in the common bile duct may, as a result of hemobilia, be mistaken for a calculus. A tumor of the gallbladder enveloping the common hepatic duct may be indistinguishable from one originating in the duct itself.

Leon Schiff, M.D.
Coral Gables

THE PATIENT RECOVERED. THE PHYSICIAN DIDN'T.



Of all the recoveries you face, the recovery of income can be the hardest of all.

Staggering Medicare, HMO and other insurance paperwork requirements can tie up your cash flow— and restrict the profitability of your practice.

You need a system that will not only speed along the collections process, but one that will increase the financial efficiency of *every* aspect of your practice—from filing claims to scheduling patients.

You need Quick Recovery.™

QUICK RECOVERY. DEVELOPED BY PHYSICIANS FOR *PHYSICIANS.*

Utilizing the IBM System/36, Quick Recovery lets you automate your entire billing, collections, and operations functions. The filing, tracking and automatic refiling of insurance claims. Even appointment scheduling and patient inquiries.

And unlike systems that are developed and then adapted to different businesses, Quick Recovery was created specifically for medical professionals, *by* medical professionals.

Through our affiliation with the Sacred Heart Health System, we developed Quick Recovery by working closely with physicians and health care professionals. The result? A totally computerized office management system ideal for today's single and multi-practice offices.

GIVE YOUR OFFICE A QUICK RECOVERY CHECKUP.

To find out more about Quick Recovery and how it can benefit your practice, call Gulf Coast Diversified, Inc. toll free at 1-800-874-1026 (1-800-342-1014 in Florida,) or fill out the coupon below. We'd be happy to give your office a no-obligation Quick Recovery checkup.

Don't wait. It's time you put your practice on the road to recovery.

YES, I'm interested in a no-obligation Quick Recovery checkup.

Name_____

Address_____

City/State/Zip_____

Specialty_____

Office phone (_____)_____

Best time to call____:____ am pm

GULF COAST DIVERSIFIED, INC.
5130 Bayou Blvd.
Pensacola, FL 32503
An affiliate of
Sacred Heart Health System

IBM
Authorized Value Added Remarketer
System 36

For Your Benefit...

From The Florida Medical Association Sponsored Insurance Plans.

Diagnosis: FMA Members and Employees, Need Dependable, Comprehensive Coverage In Medical Care, Life, Disability and Dental At Economical Group Rates

Treatment: Enroll NOW in Your Florida Medical Association Sponsored Insurance Plans

Prognosis: Excellent. FMA-SIP Offers Flexibility, Convenience, Efficiency In An Insurance Package Designed Exclusively For You.

•Major Medical •Dental •Short-Term Disability •Life And AD&D

☐ Developed from your specifications by your Association and offered exclusively to FMA members and their employees. Dependents coverage available for Medical and Dental benefits.

☐ Marketing by Florida's leading insurance consultant, Brown and Brown, Inc., for further information contact us at the toll free number below.

☐ Underwritten by one of America's largest and strongest insurance companies, Mutual of Omaha.

☐ Administered by FLAMEDCO, Inc., highly regarded for rapid, efficient claims and enrollment administration and a wholly owned subsidiary of your own Florida Medical Association.

FMA/SIP Offers You Great Flexibility. You Choose The Coverage You Need:

Major Medical, Million-dollar protection with your choice of $200 or $500 annual deductibles and the new Medical Deluxe Plan.

Dental, Benefits of up to $1,000 per person each year. Optional if you elect Major Medical.

Life, Group term life insurance coverage for you and your employees. You select coverage level from $10,000 to $100,000.

Disability, If you elect life insurance, you also may choose from among four short-term disability options, either 13-week or 26-week coverage with or without maternity.

Call Toll-Free
1-800-624-3953 *For Details*

P.O. Box 4938
Jacksonville, Florida 32201



Florida Medical Association, Inc.
Sponsored Insurance Programs

One Hundred Twelfth Annual Meeting Florida Medical Association, Inc. Diplomat Hotel September 17-21, 1986

President's Address
Luis M. Perez, M.D.

Mr. Speaker, members of the Board of Governors, Auxilians, Fellow Delegates, Ladies and Gentlemen:

This is my last formal address in this House of Delegates as your President. I come before you today with mixed emotions. It has been a great, long year. Many things have been accomplished but many more have to be followed up to completion.

When I took office, I told you that this was going to be a radical change in my life, and it has been. I had to reach deep inside me to be innovative and resourceful when all the odds were against us, and devise new ways and ideas to move the people of Florida to be our allies and influence Legislators for a favorable outcome, and this, we did.

We were faced with a constant, expanding liability insurance crisis. Through intensive work of your Leadership, for the first time in the last ten years, we were able to obtain modifications in the tort laws that surpasses the benefits obtained by many States in the Union.

This was a challenge that led to the formation of the Florida Coalition for Liability Reform in January, 1986, followed by the Assembly in Tallahassee on April 21st.

"A Day in the Right Direction" could not have been a success without the participation and unity of the medical family. I thank you for it.

And I would also like to thank at this moment, and with great admiration, our staff in Jacksonville, Tallahassee, the field offices, and the local medical societies and associations for their know-how, their clear thinking, their dedication and enthusiasm in bringing to fruition every work assigned to them in an outstanding manner.

The cooperation of most of you, visiting your Senators and Representatives, to re-enforce our cause after the assembly, was like I have never seen before.

The Auxilians were forever present, with delegation after delegation coming to Tallahassee and being very persuasive when dealing with Legislators, even the ones that were not sympathetic to us; to them, we owe a debt of gratitude.

At the late hours of June 6, the end of the 60 days Legislative Session, a compromise passed the Senate and was approved in the House at 1:10 a.m. Believe me, it was a happy moment for the Florida Delegation.

As expected, this Tort/Insurance Reform Program is being challenged in Leon County Circuit Court as unconstitutional, and we expect that challenge will be ultimately decided by the Florida Supreme Court.

This is why we have to continue being politically involved. We have to become involved more and more and participate and contribute to our FLAMPAC, our political arm. This is the only way to show we have



Luis M. Perez, M.D., FMA President

a strength and that we can help elect politicians that think in the same way we do about tort reform and issues which affect the health of the people of Florida.

We have a debt of honor to the Legislators that helped us, and we have to try to eliminate from re-election the ones that did not.

It is very inspiring to see that our medical family is getting involved in the political process, but we need more of the same. The physicians in Florida are coming to realize that being active in the political arena is the only way to protect our profession.

I want to tell you something very personal. I am going to get out of my speech for a little while, because this is very deeply ingrained in me and maybe it is the motivation for everything I have accomplished in this country.

As you know I came to this country from Cuba. I came from Cuba in 1956 — that is B.C., Before Castro. When Castro took power, I remained to a point indifferent, because I, as a physician, did not have to get involved in politics. Politics is a dirty thing. People compromise, people bend their beliefs and their faith and they do things to obtain things.

We doctors cannot compromise in anything, we do it right, we do it straight, or we do not do it. My mentality in politics was like that of most doctors in this state: I do not have to get involved in this type of thing. I want you to know that my friend Fidel Castro got involved in that type of thing and took my country from me, and I lost my country by default because I did not get involved and fight it.

Now I lost one country and I am not afraid to lose this one, but I am very, very afraid to lose my profession. And it is not going to happen without my yelling, screaming, kicking, biting, or doing anything I have to do to try to protect it. I am not going to lose by defeat. So I am going to participate in every political arena I can put myself into, and I am going to motivate as many people as possible to do the same thing. I am going to help the candidates of my choice because they are the ones who have my own beliefs, right or wrong, but they are my beliefs. And I am going to try to destroy the ones who do not, and I am going to put all my efforts in doing so, because this is the only way that you can preserve your sanity and you can feel comfortable within yourself. Thank you.

Now, our activities were not limited only to political arena. We expanded the lines of communication between membership and executives by publishing *ET* weekly for executives and *FMA Today* for the whole membership, letting you know about the activities and new developments of your Association.

We also opened an FMA Medical/Legal "Hotline" to assist members on medical legal questions and with contracts with entities.

Bills were also introduced this year, planting the seeds for better medical care for the elderly and the indigent.

We have been in contact with the leadership in the House and Senate as well as the HRS, and the opportunities to be successful are there. It only takes perseverance and unity of purpose.

Your Association is also actively involved in medical care in the state prisons. There is a great need in these institutions for continuous evaluation and revision of their medical care, due to limited facilities that make crowding and sanitary conditions very difficult.

Better accessibility to well qualified practitioners and institutions are necessary and better screening when inmates are admitted to the existing facilities is of utmost importance.

We have been, and are, very concerned about the drug problems in the state and in the country. Speaker bureaus, composed of physicians, law enforcement officers, lawyers, judges and ex-addicts should be formed in each county and in a constant and methodic schedule visit schools, churches, civic clubs, youth centers and every possible group of youngsters that may be available, to educate the general population about the infamous consequences of this crime against society. I hope the local medical societies take leadership positions in this endeavor.

Membership development is also crucial if we, as organized medicine, are to maintain an influential voice in health care matters at the state and national levels.

Your Florida Medical Association and the American Medical Association are here to represent us, the physicians, during these trying times of alternate delivery systems and DRGs. We need your membership in both Associations.

At the State level, we can decide among ourselves how we are going to confront local and national problems. But our influence at national levels, depends on the input we can have at the AMA to direct their actions in a constructive and positive way, because the AMA is the strongest voice for medicine in Washington today. Remember, it is from Washington where all our serious problems are generated.

In summary, this has been a long, hard and exciting year. I had the pleasure to visit many medical societies, renew old friendships and make a lot of new friends.

Unity was my theme for the year. I am pleased and happy to know first hand, the caliber of people that make our medical family, from individual doctors and their families, local medical societies and associations, the FMA staff in Jacksonville, Tallahassee and the rest of the state.

For this unity, for your tremendous effort and great cooperation, I thank you.

First House of Delegates

The First House of Delegates convened at 10:30 a.m. on Thursday, September 18, 1986 in the Regency East/South Room of the Diplomat Hotel, Hollywood, Florida, with Guy T. Selander, M.D., Speaker of the House, presiding.

The House rose for the invocation which was given by Charles T. Kahn, M.D., remained standing for the Pledge of Allegiance and the singing of the "The Star Spangled Banner" led by Arthur L. Eberly, M.D., and played by Pierre J. Bouis Jr., M.D.

Dr. Selander announced the membership of the Credentials Committee:

Kenneth C. Kiehl, M.D., Chairman
David R. Arrowsmith, M.D.
E. Joan Barice, M.D.
Brian P. Gibbons, M.D.

The Delegates were reminded that they must register with the Credentials Committee before this and every meeting of the House of Delegates.

Dr. Kenneth C. Kiehl, Chairman of the Credentials Committee, announced that 228 Delegates were present, representing 36 component county societies, which constitutes a quorum.

A motion carried to seat the Delegates.

Delegates

ALACHUA — O. Frank Agee, M.D.; Mark V. Barrow, M.D.; Thomas D. Bartley, M.D.; Robert K. Casey, M.D.; James O. Dailey, M.D.; J. Lee Dockery, M.D.; Thomas H. Mocre Jr., M.D.; Mr. Manuel R. Padron, Student Delegate

BAY — James T. Cook III, M.D.; Stephen J. Toner, M.D.; Ted R. Wilson, M.D.

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D.; Richard I. Barr, M.D.; Glenn E. Bryan, M.D.; Onofre P. Carrillo, M.D.; Brian J. Ellis, M.D.; Brian P. Gibbons, M.D.; Robert C. Ufferman, M.D.

BROWARD — Leroy G. Appell, M.D.; Anna M. Blenke, M.D.; Bruce B. Burgess, M.D.; Ernest Costantino, M.D.; David A. D'Alessandro, M.D.; George T. Edwards, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; James A. Jordan, M.D.; Linda J. Kaplan, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Arthur E. Palamara, M.D.; Richard D. Shafron, M.D.; Marvin L. Stein, M.D.; Peter A. Tomasello, M.D.; Juan S.A. Wester, M.D.; Alan J. Yesner, M.D.; Nelson R. Zide, M.D. (Absent — Andre S. Capi, M.D.; Phillip A. Caruso, M.D.; George J. Crane, M.D.; Wilbur F. Helmus, M.D.; Ernest G. Sayfie, M.D.; Arnold L. Tanis, M.D.)

CAPITAL — Robert P. Johnson, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — W. Randall Jenkins, M.D.; Samuel R. Miller, M.D.

CLAY — Charles E. Phillips, M.D.; Darrel W. Wyatt, M.D.

COLLIER — Charles S. Eytel, M.D.; Donald W. Ketterhagen, M.D. (Absent — Virgil A. Ponzoli Jr., M.D.)

COLUMBIA — (Absent — Nanjunda Swamy, M.D.)

DADE — Edward R. Annis, M.D.; Allen Baumal, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Edward J. Feller, M.D.; Miguel Figueroa, M.D.; Denio O. Fonseca, M.D.; Humberto L. Fontana, M.D.; Simon J.H. Frank, M.D.; N. Ralph Frankel, M.D.; Richard L. Glatzer, M.D.; Paul A. Gluck, M.D.; Enrique L. Gomez, M.D.; James J. Hutson, M.D.; Donald E. Johnson, M.D.; Norman M. Kenyon, M.D.; Warren Lindau, M.D.; Simon E. Markovich, M.D.; Linda A. Marraccini, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto, M.D.; Pedro A. Ramos, M.D.; William I. Roth, M.D.; A. Frederick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C.S. Skinner, M.D.; Marvin B. Slotkin, M.D.; Ruben Urrutia-Carpio, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Bruce W. Weissman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D. (Absent — Manuel Abella-Fernandez, M.D.; Carlos L. Abraira, M.D.; Jerome Benson, M.D.; Pedro P. Bosch, M.D.; James W. Bridges, M.D.; Efrain Camara, M.D.; Harlan S. Chiron, M.D.; B. David Epstein, M.D.; Carlos G. Llanes, M.D.; Sheldon D. Munach, M.D.; Oscar Sandoval, M.D.; Douglas Slavin, M.D.; Charles F. Tate, M.D.; Mr. George David Markovich, Student Delegate)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Clyde M. Collins, M.D.; James H. Corwin II, M.D.; Patricia C. Cowdery, M.D.; Wilbert L. Dawkins, M.D.; Joseph D. Foley, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; Charles B. McIntosh, M.D.; Kevin M. McAuliffe, M.D.; Sanford A. Mullen, M.D.; H. Warner

Webb, M.D.; C. Davis Whelchel III, M.D. (Absent — Gaston J. Acosta-Rua, M.D.; Harvey E. Bernhardt, M.D.; H. Joe Hurlbut, M.D.; John F. Lovejoy, M.D.; Jack L. Sapolsky, M.D.; Seabury D. Stoneburner Jr., M.D.; George S. Trotter, M.D.)

ESCAMBIA — Paul T. Baroco, M.D.; Eric F. Geiger, M.D.; Everett S. Havard, M.D., Charles J. Kahn, M.D.; James M. Potter, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson Jr., M.D.

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Richard G. Spindler, M.D. (Absent — Eustus Nelson, M.D.)

HILLSBOROUGH — Miguel R. Alonso, M.D.; Pierre J. Bouis Jr., M.D.; William T. Branch, M.D.; Lawrence S. Cohen, M.D.; Frank C. Coleman, M.D.; Irving M. Essrig, M.D.; Mutaz B. Habal, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Thomas E. McKell, M.D.; Ralph E. Rydell, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow, M.D. (Absent — Richard G. Connar, M.D.; Robert E. McCammon, M.D.; Ronald L. Seeley, M.D.; Mr. Chris Centeno, Student Delegate)

INDIAN RIVER — Donald L. Ames, M.D.; Paul A. Graham, M.D.; Kip Kelso, M.D.

LAKE — John L. Geeslin, M.D.; Joseph E. Holland, M.D. (Absent — William H. Shutze, M.D.)

LEE — William R. Bess Jr., M.D.; Robert J. Brueck, M.D.; Larry P. Garrett, M.D.; F. Lee Howington, M.D.; T. T. Knight, M.D.; Marcus M. Moore, M.D.; Douglas A. Newland, M.D.

MADISON — M. Linda Dulay, M.D.

MANATEE — Thomas R. Busard, M.D.; Gary L. Dunlap, M.D.; Julian Giraldo, M.D. (Absent — George R. McSwain, M.D.; Gerald G. Whitt, M.D.)

MARION — Henry L. Harrell Jr., M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D. (Absent — Andrew F. Greene, M.D.; James M. Hayes, M.D.)

MONROE — (Absent — Ronald H. Chase, M.D.)

NASSAU — Cecil B. Brewton, M.D.

OKALOOSA — (Absent — David R. Arrowsmith, M.D.; William W. Thompson, M.D.)

ORANGE — Richard J. Bagby, M.D.; Henry J. Baskin, M.D.; Clarence H. Brown III, M.D.; Manuel J. Coto, M.D.; Jay M. Hughes, M.D.; Angelo Massaro, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Calvin R. Peters, M.D.; Wallace M. Philips Jr., M.D.; James F. Richards Jr., M.D.; Philip N. Styne, M.D.; Thomas B. Thames, M.D.; Cecil B. Wilson, M.D. (Absent — Wayne L. Godbold, M.D.; David L. Mackey, M.D.)

OSCEOLA — Alonzo J. Logan, M.D.; Gilberto Perez, M.D.

PALM BEACH — E. Joan Barice, M.D.; Richard C. Cavanagh, M.D.; McKinley Cheshire, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; V.A. Marks, M.D.; William J. Romanos Jr., M.D.; Anthony L. Thebaut, M.D.; Milton R. Tignor, M.D.; Dick L. Van Eldik, M.D. (Absent — James D. Daughtry, M.D.; Douglas D. Dedo, M.D.; George L. Ford, M.D.; J. Russell Forlaw, M.D.; Gilbert R. Panzer, M.D.; Myron M. Persoff, M.D.; Joel F. Smith, M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Carl W. Graves, M.D.; Marc S. Freedman, M.D.; Maynard F. Taylor, M.D.

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; John M. Hamilton, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris LeVine, M.D.; John E. Meyer, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Bruce P. Smith, M.D. (Absent — Charles K. Donegan, M.D.; William E. Hale, M.D.; Howard L. Reese, M.D.; William H. Schmid, M.D.; James L. West, M.D.)

POLK — Annette C. Barnes, M.D.; Francis D. Drake, M.D.; Richard M. Garcia, M.D.; John W. Glotfelty, M.D.; Henry M. Haire, M.D.; David T. Jones, M.D.; Thomas E. McMicken, M.D.; Robert B. Peddy, M.D.; Dale L. Taylor, M.D.

PUTNAM — Roy E. Campbell, M.D.

ST. LUCIE-OKEECHOBEE — David Fromang, M.D. (Absent — Two Delegates)

SANTA ROSA — (Absent — David B. Young, M.D.)

SARASOTA — William E. Bush, M.D.; John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Charles R. Mathews, M.D.; Franklin H. Pfeiffenberger, M.D.; Karl R. Rolls, M.D.; Ernest C. Smith Jr., M.D.; Phyllis A. Stephenson, M.D.; David L. Thomas, M.D.

SEMINOLE — Frederick J. Weigand, M.D.; Orlando Garcia-Piedra, M.D.; Maria P. Perez, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Andrew C. Bass, M.D.)

TAYLOR — (Absent — John H. Parker, M.D.)

VOLUSIA — H. Frank Farmer Jr., M.D.; Richard Huster, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.; H.S.B. Treloar, M.D.

WALTON — (Absent)

WASHINGTON — (Absent)

SPEAKER OF HOUSE — Guy T. Selander, M.D.

VICE SPEAKER — Arthur L. Eberly, M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

SPECIAL GROUP DELEGATES

ANESTHESIOLOGISTS, FLA. SOC. OF — Jimmie D. Moore, M.D.

COLON AND RECTAL SURGEONS, FLA. SOC. OF — Kimber A. Ward, M.D.

INTERNAL MEDICINE, FLA. SOC. OF — Robert T. Meade, M.D.

OBSTETRIC & GYNECOLOGIC SOC., FLA. — Robert T. Hoover, M.D.

OCCUPATIONAL MEDICAL ASSN., FLA. — Than Myint, M.D.

OPHTHALMOLOGY, FLA. SOC. OF — Tully C. Patrowicz, M.D.

ORTHOPEDIC SOCIETY, FLA. — Arthur Pearl, M.D.

OTOLARYNGOLOGY, HEAD & NECK SUR., FLA. SOC. OF — William W. McClerkin, M.D.

PATHOLOGISTS, FLA. SOC. OF — Jerry L. Harris, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEONS, FLA. SOC. OF — Jeffrey Long, M.D.

PREVENTIVE MEDICINE, FLA. SOC. FOR — Donald S. Kwalick, M.D.

PSYCHIATRIC ASSN., CO. OF FLA. DIST. BRANCHES OF THE AMERICAN — George W. Metcalf, M.D.

SURGEONS, FLA. ASSN. OF GENERAL — R. Bradford Pyle, M.D.

SPECIALTY GROUPS WITH NO DELEGATE REPRESENTATION

Allergy and Immunology Soc., Fla.
Chest Physicians, Amer. Coll. of, Fla. Chapter
Dermatology, Fla. Soc. of
Emergency Physicians, Am. Coll. of, Fla. Chap.
Endocrine Society, Fla.
Family Physicians, Fla. Academy of
Gastroenterologic Soc., Fla.
Neonatal Perinatologists, Fla. Soc. of
Nephrology, Fla. Soc. of
Neurology, Fla. Soc. of
Neurosurgical Society, Fla.
Nuclear Physicians, Fla. Assn. of
Oncology, Fla. Soc. of Clinical
Pediatric Cardiologists, Fla. Assn. of
Pediatric Soc., Fla., and Pediatrics, American Academy, Fla. Chap.
Pediatric Surgeons, Fla. Assn. of
Physical Medicine and Rehab., Fla. Soc. of
Physicians, American College of, Fla. Region
Radiological Society, Fla.
Rheumatology, Fla. Soc. of
Surgeons, Amer. College of, Fla. Chapter
Surgeons, International College of, Fla. State Surgical Division
Thoracic and Cardiovascular Surgeons, Fla. Soc. of
Thoracic Society, Fla.
Urological Society, Fla.

Information for Delegates

The Rules and Order of Business for the House of Delegates are included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. **The Bylaws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance,** and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Your attention is called to the format of the Annual Meeting, where the Reference Committee meetings will be held on Friday morning, following the First Meeting of the House on Thursday morning. All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates.

All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairmen to defer items in which they are interested in order that they may be present to discuss the subject.

All resolutions **must have a sponsor present before the Reference Committee.** Resolutions must be filed by 12:00 noon on the day before the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be available for distribution by the time the First House convenes. Only the "Resolved" portion of the resolutions will be adopted as policy.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, (as well as the reports of the Reference Committees) have been printed on colored paper for easy reference. This color code is as follows:

Reference Committee No. I — Green
Reference Committee No. II — Tan
Reference Committee No. III — Blue
Reference Committee No. IV — Pink
Reference Committee No. V — Goldenrod

According to our Bylaws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Guy T. Selander, M.D., Speaker
House of Delegates

Arthur L. Eberly Jr., M.D., Vice Speaker
House of Delegates

Explanation of Resolution Withdrawal

Once a resolution is placed on the agenda of the House, it becomes the property of the House, so to speak. The original presenter of the resolution may not simply withdraw it from consideration. He may speak against it at the Reference Committee and request the Reference Committee to recommend disapproval.

If no sponsor appears before the Reference Committee, the Reference Committee is at liberty to treat the resolution the same as any other on its agenda. It may amend, recommend approval, etc. But, if no sponsor is present to speak for it, the Reference Committee may, and usually does, simply recommend disapproval.

In any event, some action must be taken by the House on every item on the agenda as of this moment.

A motion carried to waive the requirement of FMA membership for the Good Samaritan Award recipients.

A motion carried to adopt the Minutes of the 1985 House of Delegates and 1986 Interim Meeting as published in the August, 1986 and March, 1986 issues of *The Journal of the Florida Medical Association, Inc.*, respectively.

The Speaker introduced the officers of the Association: Frank C. Coleman, M.D., Immediate Past President; Henry M. Yonge, M.D., Secretary; James B. Perry, M.D., President-Elect; Arthur L. Eberly, M.D., Vice Speaker; Yank D. Coble Jr., M.D., Treasurer; Luis M. Perez, M.D., President; James G. White, M.D., Vice President; Donald C. Jones, Executive Vice President.

Dr. Eberly introduced distinguished guests Dr. Rufus K. Broadaway, AMA Trustee; Dr. Edward R. Annis, AMA Past President; Mrs. Edie Epstein, AMPAC Board Representative and AMA Auxiliary; Mrs. Jo Tignor, FMA Auxiliary President; Mrs. Susan Marks, FMA Auxiliary President-Elect. The Vice Speaker called for a moment of silent meditation and prayer in the memory of those members of the Association lost through death since last year and especially FMA Past President, Duncan T. McEwan, M.D.

Remarks — Speaker of the House

At this time, I would like to welcome you to the 112th Annual Meeting of the Florida Medical Association. As delegates from your respective county medical societies, specialty groups and the hospital staff section, you have been given the privilege and responsibility for charting the course of our medical association on behalf of the 15,000 plus members. The previous House of Delegates saw fit to include a delegate to this House from each recognized specialty society, and from the newly formed and well functioning hospital staff section. This broad representation should ensure that all of our members have a voice and will enhance the democratic process as we deliberate our business.

Let me give you the format for this year's House of Delegates:

Today, the First House will meet as outlined on page 22 of your Delegates packet. As you can see, today's business will be primarily awards, the President's Address and the assignment of Reference Committee material and personnel.

Tomorrow, all five Reference Committees will meet at 8:30 a.m. in their assigned rooms. It is in the arena of the Reference Committees that most of our discussion and debate should take place. Any member of the FMA may be heard during these deliberations.

Some members may feel compelled to speak at more than one Reference Committee. If you request that the Chairman hold discussion until a certain time, this can usually be accommodated. The substance of our Reference Committee deliberations this year will include bylaws changes, a dues increase, changes in the dues structure for different categories of membership and many Legislative considerations.

Upon completion of the Reference Committee agendas, the Reference Committees and staff will go into executive sessions to prepare their reports. It is our intention to have a copy of each report available for each county medical society by Friday afternoon.

The Second House will convene on Saturday at 2 p.m. During this session we will hoepfully discuss at least three Reference Committee reports, accept nominations for the elective offices outlined on page 23 and promptly recess at 4:30 p.m. This will allow everyone time to prepare for the President's Inauguration at 5:30 p.m. in the Regency West Room.

On Sunday morning we will have elections, finish the Reference Committee reports and complete our business. Every Delegate is required by our Bylaws to fill out an attendance card at each meeting of the House. The Chairman of the Credentials Committee will report to the House the number of delegates registered, thus eliminating the necessity of a roll-call vote.

Our deliberations are governed by Parliamentary procedure as contained in *Sturgis' Standard Code of Parliamentary Procedure*, unless otherwise provided by FMA Charter and Bylaws or modified by a two-thirds vote of the members present at any session.

It is the intent of the Vice Speaker, Dr. Eberly, and myself to allow all to be heard. In view of the opportunity for each Delegate to speak at the Reference Committee, you are encouraged to be concise, and make pertinant remarks when compelled to further discuss any of the issues on the floor of the House.

We have a busy four days ahead of us; work hard and we will all survive it for the good of the order. Thank you.

The remarks of the Speaker of the House were referred to Reference Committee III for consideration.

At this time, Dr. Selander proceeded to introduce FMA President, Luis M. Perez, M.D., to present several awards. A more formal introduction of the President will occur later in the agenda.

Dr. Perez then presented the A.H. Robins Award for Outstanding Committee Service by a Physician. Dr. Perez introduced Mr. Gerald W. Kerlin Jr., C.M.R., A.H. Robins Southeastern Division of Penbroke Pines, and announced that Dr. Bernard Kimmel, of West Palm Beach, was the recipient of the award. Dr. Perez then requested that Dr. William J. Romanos Jr., of Palm Beach County, escort Dr. Kimmel to the podium to receive the award.

A.H. Robins Company Award For Outstanding Community Service By a Physician

Bernard Kimmel, M.D., a practicing Family Physician in West Palm Beach, Florida, has been selected by the Board of Governors of the Florida Medical Association, upon nomination of the Palm Beach County Medical Society, as the recipient of the 1986 A. H. Robins Company Award for Outstanding Community Service by a Physician.



FMA Speaker of the House, Guy T. Selander, M.D., and Vice Speaker, Arthur L. Eberly Jr., M.D.



Dr. Bernard Kimmel receives the A.H. Robins Company Award from Dr. Luis M. Perez, FMA President.

A native of Highland Park, Michigan, Dr. Kimmel received his medical degree from the University of Michigan. He completed additional medical training at the Physical Therapy School at the Mayo Clinic in Rochester, Minnesota, and post-graduate hospital training at Toledo Hospital in Toledo, Ohio.

Dr. Kimmel has served in various capacities with Doctors Hospital, John F. Kennedy Hospital and Good Samaritan Hospital.

He is a member of the Palm Beach County Medical Society in which he has served his medical society as its Treasurer, Secretary and President and serves as a Delegate to the Florida Medical Association House of Delegates.

This active physician also belongs to the American Academy of Family Physicians and has served as past President, Vice President, Director and Chairman of the Board.

He is a member of the American Heart Association, the American Legion, B'nai B'rith, United Coalition of Handicapped Voters and Board of Directors of Special Olympics of Palm Beach County.

Dr. Kimmel has further served his community by being team physician for Forest Hill High School football team, voluntary physician for the Palm Beach County School Patrol on field trips to Washington, D.C., and as a member of the Palm Beach County School Board, Florida Executive Committee of Business Consortium for the Gifted and Talented, Sheriffs Advisory Committee of Law Enforcement and Palm Beach County Legislative Coalition.

He was elected to the Florida House of Representatives in 1980 and served for two years and was re-elected in 1984. He received, in 1982, the prestigious Allen Morris Award as runner up for The Most Effective First Term House Member.

Dr. Perry proceeded to announce that Mrs. Betty Duda, of Orlando, was the recipient of the 1986 Distinguished Layman Award. Mrs. Duda was not present to receive the award, but it will be presented at a later date by the Orange County Medical Society.

Distinguished Layman Award
Mrs. Betty Duda

Whereas, Mrs. Betty Duda of Orlando, Florida, has been a tireless and generous supporter of Florida philanthropic and humanitarian causes for many years; and

Whereas, The death of her small daughter due to leukemia prompted her to become involved with the Leukemia Foundation; and

Whereas, In 1983 Mrs. Duda received the prestigious Service to Mankind Award from the Leukemia Society of America, in honor of her extensive achievements and contributions to the community; and

Whereas, This active woman recently participated in the Orange County Medical Society's "Mini-Internship Program" and is now one of the Program's strongest supporters; and

Whereas, She has served as Board Member of the State of Florida Fair and on the State of Florida Vocational Educational Commission; and

Whereas, She has served Concordia College in Bronxville, New York, as a Board Member and Rollins College as Board Vice President; and

Whereas, This benevolent individual has been a Board Member of the Central Florida Blood Bank, President of the Central Florida Civic Theater and Board Member of the Central Florida Fair; and

Whereas, Mrs. Duda has served the Greater Orlando Chamber of Commerce and Orlando Symphony as a Board Member, Orlando/Winter Park Junior League as President and the Lock Haven Art Center as President of the Board; and

Whereas, She was Vice President for Mission Projects for Lutheran Women, which was a national office; and

Whereas, For ten years this gracious lady did volunteer work for Winter Park Memorial Hospital and ended her volunteer work with the hospital as President of the Board; and

Whereas, This kind lady was born in Chicago, Illinois, and moved to Orlando at the age of 18; and

Whereas, Mrs. Duda continues to serve her community with her talents, energy and time; therefore be it

RESOLVED, That upon unanimous vote of the Board of Governors of the Florida Medical Association at its 112th Annual Meeting in Hollywood, Florida, September 17-21, 1986 presents to Mrs. Betty Duda its Distinguished Layman Award.

Medical Speakers Awards

The medical profession in Florida has benefited in recent years from increased communications on the part of county medical societies and physicians in health-related television and radio programs.

This type of media activity is encouraged by the FMA. We established the Medical Speakers Awards to recognize some of these outstanding programs and the people who have made them successful.

This year's seven First Place award winners will receive a plaque and a check for $100.

In the category of Organizational Television, there was a tie between Duval County Medical Society and Collier County Medical Society.

One First Place award went to Duval County Medical Society for their weekly program entitled "To Your Health." This 36-program series represents a long-term commitment on the part of the Duval County Medical Society to give their community much needed medical and health information which helps the citizens better utilize the total health care delivery system. Dr. Charles P. Hayes Jr., President of Duval County Medical Society, accepted the award.

Collier County Medical Society also received a First Place award in Organizational Television for their weekly program "Med-Line-3" which began in September of 1985. These programs cover a variety of broad medical and medical/economic topics.

For the fourth year in a row, the winner in the Organizational Radio category was the Duval County Medical Society. Their weekly call-in radio program entitled "Ask the Doctor" is broadcast over WOKV Radio in Jacksonville. Guest physicians talk about topics ranging from anesthesiology to urology. Once again, Duval County Medical Society is commended for their long-term commitment to the medical/health information needs of the Jacksonville community. Dr. Hayes accepted the award.

Our next category is Individual Radio and this year's winner was the Executive Vice President from the Orange County Medical Society, Mr. Ron Fitzwater.

Mr. Fitzwater's talk, "Orange County Medical Society's Five Year Mission" was a one-hour program orienting listeners to the Orange County Medical Society and its services and making the community more aware of the health care services that are now available. Mr. Fitzwater accepted the award.

We had another tie and it was in the category of Individual Live Audience Presentation. This tie went to two gentlemen who just happen to have spoken on the same topic, "The Health Care Witness," presented at the Physicians and Allied Health Symposium. This conference was designed to assist physicians and other health care professionals in understanding and participating as witnesses in the legal system.

This award went to Dr. J. Darrel Shea, of Orlando, and to Joseph M. Taraska, Esquire, of Orlando. Mr. Taraska accepted Dr. Shea's award on the doctor's behalf, as well as his own.

The last of our Medical Speakers Awards goes to a specialty group whose entry did not fit any of the designated categories, so a new category was created. This year's winner in the new category of Public Relations Campaigns goes to the Jacksonville OB/GYN Society for their entry "Enough is Enough." This public relations campaign, which included radio and television spots, billboards, advertisements and print material, was produced to develop public awareness in voters ages 18-35 regarding the professional liability crisis and the threat it poses for the delivery of health care in high risk specialties such as OB/GYN. Dr. Hayes accepted the award for the society.

Dr. Selander then called on Dr. Perry to announce the recipient of the Malpractice Prevention Award. Dr. Perry presented the Malpractice Prevention Award to Luis M. Perez, M.D., of Sanford.

1986 Malpractice Prevention Award

Florida Medical Association President Luis M. Perez, M.D., a practicing cardiologist in Sanford, Florida, has been selected by the Board of Governors of the Florida Medical Association, upon nomination of Orange County Medical Society, as the recipient of the 1986 Malpractice Prevention Award.

Throughout his term as President of FMA, Dr. Perez devoted his full energy to seeking a solution to the continuing professional liability crisis. An important element of that effort was the formation of the Florida Coalition for Liability Reform and the Assembly for Liability Reform in Tallahassee on April 21, 1986. Dr. Perez was primarily responsible for the formation of the FCLR and organization of the highly successful "Assembly in Tallahassee."

Dr. Perez has also appeared on numerous television programs on the local, state and national levels to discuss and debate the professional liability issue and has given many statements to the electronic and print media. He has also testified before numerous legislative committees.

He is a native of Camaguey, Cuba; received his medical degree from Havana Medical School in Havana, Cuba, and completed postgraduate training, an internship and residency in internal medicine and cardiology at Georgia Baptist Hospital in Atlanta, Georgia.

From 1960-1963 Dr. Perez served as a personnel physician at the Florida State Hospital in Chattahoochee, Florida, and in 1963 opened a private practice of internal medicine and cardiology in Sanford, Florida.

He is a member of numerous state, national and international medical societies including Seminole County Medical Society, Florida Medical Association, Florida Society of Internal Medicine, American Medical Association, American College of Chest Physicians, Southern Medical Association, World Medical Association, and International College of Angiology.

He is Past President of Seminole County Medical Society, Seminole County Delegate to Florida Medical Association, Florida Medical Association Delegate to American Medical Association, Florida Medical Association President-Elect, Chairman of Allied Health Profession and Chief of Staff of Seminole Memorial Hospital.

Not only is Dr. Perez active in medical organizations, but also in civic, community and governmental organizations including member of Greater Sanford Chamber of Commerce, Founder of Seminole County Drug Action Committee, member and Secretary of Civil service Board and Founder and Advisor of *The Grove*, a drug detoxification center.

Dr. Perez has received many honors and awards including A. H. Robins Award for Outstanding Community Service by a Physician, Americanism Medal from the Daughters of the American Revolution, Dr. Benjamin Rush Bicentennial Award, American Medical Association Physician Speakers Award and Sanford Kiwanis Club Outstanding Community Services Award.



FMA President, Dr. Luis M. Perez accepts the 1986 Malpractice Prevention Award from President-Elect Dr. James B. Perry.

Medical Speakers Award


1



2



3



4

(1) Dr. Donald W. Ketterhagan accepts the award for Organizational Television, (2) Mr. Ron Fitzwater, Executive Vice President of Orange County Medical Society, accepts his award for Individual Radio, (3) Joseph M. Taraska, Esquire accepts the Individual Live Audience Presentation award for himself and Dr. J. Darrel Shea, (4) Dr. Charles P. Hayes Jr., President of Duval County Medical Society, accepts one of the awards won by the Duval County Medical Society. Duval County received awards for Organizational Television and Organizatonal Radio. Dr. Hayes also accepted the award for Public Relations Campaigns on behalf of the Jacksonville OB/GYN Society.

Dr. Selander then called on Dr. Pierre J. Bouis Jr., to announce the winners of the 1986 Scientific Exhibit Awards.

1986 Scientific Exhibit Awards

First Place:
"Surgical Management of Deafness"
Jay B. Farrior, M.D.

Second Place:
"Treatment of Amputated Parts"
Felix Freshwater, M.D.

Third Place:
"What's New in Scoliosis"
Charles T. Price M.D.

Honorable Mention:
"Early Effects of Extracorporeal Shock"
J.V. Kaude, M.D.

"Cranio-Maxillo Facial Surgery"
M. Habal, M.D.

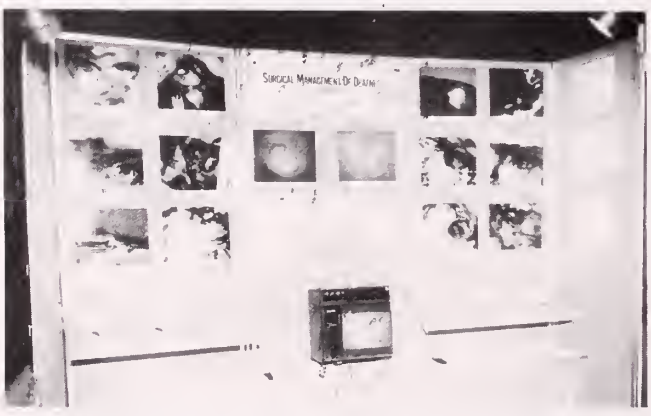
"22-Gauge Needle Guide"
Irvin F. Hawkins, M.D.

Certificate of Grateful Recognition

Dr. Selander announced that Clarence L. (Carl) Brumback, M.D., M.P.H., was the recipient of a Certificate of Grateful Recognition, but due to a prior commitment was unable to be present to receive the certificate. It will be presented at a later date.

1986 Awards for Excellence in Medical Journalism

Dr. Selander announced that the 1986 Awards for Excellence in Medical Journalism were presented at a luncheon on Wednesday, September 17.



Dr. Jay B. Farrior received first place in the 1986 Scientific Exhibit Awards for his exhibit "Surgical Management of Deafness."

PRINT ENTRIES
Dailies over 50,000
Steve Sternberg
"Multiple Sclerosis in Key West"
The Miami Herald

Dailies Under 50,000
Gene Casey
"Countdown"
Charlotte Sun

Weeklies
Theresa Defino, Burt Schorr, Steve Rothman, Avram Goldstein, Jorge Aquino
"International Medical Centers HMO Series"
South Florida Medical Review

Magazines
Celeste O. Cox
"An Interview with Norman Cousins"
Spiritus — The Magazine of St. Mary's Hospital, West Palm Beach

Audio/Visual Entries
Television, Major Metropolitan Areas
Art Carlson
"Sex Selection"
WPLG-TV Miami

Television, Small Cities
Leisa Zigman
"Who's at Fault?"
WBBH-TV Fort Myers

Radio
Lee Hall, Donna Howell, Wayne Weinberg
"New Heart, New Life"
WDBO Orlando

Second Place Winners

Print Entries
Dailies Over 50,000
Fred Schulte
"Veterans Administration Medical Quality Series and Related Articles"
Ft. Lauderdale News and Sun Sentinel

Dailies Under 50,000
Sam Rohlfing
"Your Health"
Vero Beach Press-Journal

Weeklies
Wendy McMullen
"Poison Ivy: The Facts and Fallacies About This Menace to Mankind"
Island Reporter, Sanibel

Magazines
Carol Cohen
"Medicine's New Image: Magnetic Resonance"
Message Magazine, Miami, Mt. Sinai Medical Center

Audio/Visual Entries
Television, Major Metropolitan Areas
John Miller, Ph.D. and Michael Juliano
"South Florida Cocaine"
WSVN Miami

Television, Small Cities — tie
Joe Larkins
"Health Watch on Stroke"
WTXL Tallahassee

Kathy McClintock
"Out of the Closet — PMS"
WINK Fort Myers

Radio — tie
David Brandao
"Eating Disorders — When Food Controls You"
WDBO Orlando

Shari Szabo, Beth Foushee, John Bond and Dick Eyrich
"News Coverage of the Heart Transplant of Lakeland Resident Frank Spurlin in June 1985"
WONN/WPCV Lakeland

Honorable Mention Winners

Audio/Visual Entries
Television, Small Cities
Marilys Llanos
"Kidney Transplant — Organ Transplant"
WSCV Hollywood

Radio
John S. Koch
"Public Affairs Saturday Morning Coffee Program"
WNER/WQHL Live Oak

At this time, Dr. Selander proceeded to introduce FMA President, Luis M. Perez, M.D.

Introduction of President

Being Speaker of the House of Delegates has its highs and lows, its good parts and its bad parts. We are now on a high. We have arrived at another good part.

It has been sixteen months since our last Annual Meeting and what months those have been! Recovering from the bitter disappointments of previous years, we acquired, at long last, some useful tools in our unending efforts to bring the medical malpractice crisis under control.

In the wee hours of last June 7, in the State Capitol at Tallahassee, our years of hard work paid off. The House of Representatives approved a compromise tort reform package just as the Senate had approved it less than an hour earlier.

Our success, of course, was brought about by the untiring efforts of a multitude of people — FMA members and staff, Auxiliary, Legislators and many others. But if we had to recognize one person — just one man — as having been responsible for this remarkable achievement, it would have to our 109th President — Luis Perez.

Luis began preaching the need for unity to us 16 months ago, and he hewed to that theme all during his Presidency. It paid off.

Early on, in conferences with Legislative leaders, Luis was told there would be no tort reform in 1986. Such negative attitudes, of course, were totally unacceptable to him.

Meanwhile, it was becoming increasingly clear that professional liability was not a problem confined to the health professions. Other areas of American commerce, business and professions were getting theirs — lawyers, day-care centers, trucking companies, architects, taxicab companies and many others. The time was ripe to marshal the energies of the various and diverse groups that were feeling the pinch, and to focus those energies on solutions, particularly in the legislative arena.

So it was that in January of this year and with the strong hand of Luis Perez, the Florida Coalition for Liability Reform was born. The Coalition has grown rapidly, and today, it boasts 89 organizations representing 700,000 members. Luis was elected Vice-Chairman of the Coalition.

It was Luis who suggested that the Coalition stage a large assembly in Tallahassee to convince legislators that the malpractice crisis was for real and they needed to act this year. Some said it should not be done. Some said it could not be done. But with Luis' leadership, it was done.

Call last April 21 what you wish — the Assembly for Liability Reform, A Day in the Right Direction or simply the Rally in Tally. The 3,500 interested individuals, including hundreds of physicians, who turned out that day were the largest assembly formed in support of a legislative issue that Tallahassee had ever seen.

The Legislature was impressed. What the Legislative leaders told Luis was not to be indeed was to be. And Luis Perez was and is our man of the hour.

Who would have ever predicted that the young boy growing up in Camaguey, Cuba in the 1930s would make such an impact on his profession in his adopted country. Since arriving in the USA a little more than 30 years ago, Luis has been such a good American and has collected so many honors that the rest of us should be envious.

I will not mention them all, but the list includes the Robins Award for Outstanding Community Service by a Physician, the AMA's Benjamin Rush Bicentennial Award and the George Washington Medal of Honor of The Freedom Foundation of Valley Forge.

Luis has served many medical organizations as both a member and a leader. He has been President of his county medical society. He has served the FMA in many ways, including Delegate to the AMA, Chairman of the Committee on Allied Health Professions, as Secretary, and now as President.

Now, it is time for the Annual Report of the President. It is with pride and pleasure that I present to you the 109th President of the Florida Medical Association — Dr. Luis Martin Perez.

Dr. Perez addressed the House (the text of Dr. Perez's remarks appear on page 927). The Remarks of the President were referred to Reference Committee III.

Corrections to the Handbook were then announced by the Vice Speaker:

The Reference Committee meetings were changed from starting at 8:30 a.m. to 9:00 a.m.

The Vice Speaker announced the members of each Reference Committee.

Reference Committee I
Health and Education

O. Frank Agee, M.D., Chairman, Alachua
Terence P. McCoy, M.D., Capital
Robert J. Brueck, M.D., Lee
Donald J. Plevy, M.D., Broward
Alvin E. Smith, M.D., Volusia
Miguel Figueroa, M.D., Dade
AMA Delegate Advisors: J. Lee Dockery, M.D., and Richard G. Connar, M.D.

Reference Committee No. II
Public Policy

William J. Romanos Jr., M.D., Chairman, Palm Beach
Walter A. Harmon, M.D., Duval
Joseph E. Holland, M.D., Lake
David Pins, M.D., Orange
Linda Marraccini, M.D., Dade
AMA Delegate Advisor: Kay K. Hanley, M.D.

Reference Committee No. III
Finance and Administration

Norman Kenyon, M.D., Chairman, Dade
Kevin M. McAuliffe, M.D., Duval
Harold L. Ishler, M.D., Pinellas
Calvin W. Martin, M.D., DeSoto-Hardee-Glades
Robert Eastridge, M.D., Palm Beach
Richard J. Bagby, M.D., Orange
AMA Delegate Advisor: Charles J. Kahn, M.D.

Reference Committee No. IV
Legislation and Miscellaneous

T. Wallace Hahn, M.D., Chairman, Broward
Paul T. Baroco, M.D., Escambia
James T. Cook III, M.D., Bay
Wilbert L. Dawkins, M.D., Duval
Larry P. Garrett, M.D., Lee
Charles P. Dunn, M.D., Dade
AMA Delegate Advisors: Joseph C. Von Thron, M.D., and Sanford A. Mullen M.D.

Reference Committee No. V
Medical Economics

Peter A. Tomasello, M.D., Chairman, Broward
Robert G. Isbell, M.D., Hillsborough
Virgil B. Ponzoli, M.D., Collier
Juan S. Wester, M.D., Broward
Daniel Seckinger, M.D., Dade
AMA Delegate Advisors: T. Byron Thames, M.D., and Lee A. Fischer, M.D.

The Speaker announced the times and locations of each Reference Committee meeting.

Dr. Selander announced that the assignments of Reports and Resolutions to Reference Committees were as indicated in the handbook except for Resolution 86A-4 which was referred to Reference Committee III instead of Reference Committee II, and Resolution 86A-12 which was referred to Reference Committee III instead of Reference Committee V.

The Vice Speaker announced the assignments of Supplemental Reports and Resolutions which were received too late for inclusion in the Handbook and which had been inserted into the Delegates packets as indicated on the Reports.

The Speaker called for any reports which were received too late to be included on the agenda. The Speaker informed the House of the House of Delegates' policy which requires any business to be considered by the House must have been submitted by 12:00 noon Wednesday, September 17. Presentation of any other reports or resolutions not already on the agenda will require an unanimous consent of the House and would have to be of an emergency nature and in writing.

E. Joan Barice, M.D., of Palm Beach County, introduced Resolution 86A-44, Malpractice Coverage for Physicians Providing Indigent Care. The motion to consider this Resolution passed and was referred to Reference Committee IV.

Ralph E. Rydell, M.D., of Hillsborough County, introduced a resolution on concurrent care. Motion was made to consider this resolution but did not receive unanimous vote. Therefore, the resolution was not considered.

Dr. Selander recognized Cecil Wilson, M.D., of Orange County, who informed the House that the Orange County Delegation will no longer wear orange blazers but now will be wearing navy blazers.

Dr. Selander announced the dates and times of the FMA Symposium on the "Care of the Aging Patient," Health Run, Good Government Luncheon, Florida Physicians Association Annual Membership Meeting, Presidential Inauguration, President's Reception, and Risk Management Seminar.

The House recessed at 11:45 a.m. to reconvene on Saturday, September 19, at 1:30 p.m.



Dr. Maria P. Perez; FMA President, Dr. Luis M. Perez; FMA Executive Vice President, Donald C. Jones; and FMA President-Elect Dr. James B. Perry.

Ninth Annual JFMA Awards Contest


1


2





4


5


6


7


8

Six county medical societies received plaques in the Ninth Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins. The awards were presented at the Annual Editor's Luncheon by Editor Dr. R. G. Lacsamana. (1) Dr. James K. Conn accepts the Special Citation for Most Improved Bulletin for CAP Scan, Capital County Medical Society. (2) Dr. F. Norman Vickers accepts one of the two awards received by Escambia County Medical Society Bulletin. Escambia County received First Place in General Excellence, Newspaper Format, and First Place for Special Recognition for its effective use of photography and art. (3) Dr. Richard J. Bagby accepts one of the two awards received by Orange County Medical Society. Orange County received First Place for Most Improved Bulletin and First Place for Best Regular Feature. (4) Dr. Robert W. Dein accepts the Special Citation for Special Recognition given to Sarasota County Medical Society Newsletter for its attempt to raise political consciousness. (5) Dr. Bagby accepts the award for Best Regular Feature given to the Orange County Medical Society Bulletin, Central Florida Physician. (6) Dr. Marc A. Flitter accepts one of the two awards received by Dade County Medical Association. Dr. Flitter accepts the Special Citation for Magazine Format in General Excellence Category for Miami Medicine. (7) DCMA Update also received a Special Citation for Newsletter Format in General Excellence Category. Dr. Harold Norman accepted the award. (8) Dr. H. Frank Farmer accepts one of the two awards received by Volusia County Medical Society. The Stethoscope received First Place in the Magazine Format of General Excellence Category. The Stethoscope also received First Place in Best Editorial for its editorial "Social Darwinism or the Social Gospel — A Matter of Conscience."

Editor's Luncheon





















This year's Editor's Dinner was changed to the Editor's Luncheon. This was the first Editor's Luncheon for Editor Dr. R. G. Lacsamana. Each year the Editorial Staff is presented with bound volumes of The Journal. Receiving their bound volumes from Dr. Lacsamana were (1) Dr. Pierre J. Bouis Jr., Contributing Editor; (2) Dr. F. Norman Vickers, Associate Editor; (3) Dr. Henry L. Harrell Jr., Associate Editor; (4) Dr. Jacques Caldwell, Medical Economics Editor; (5) Dr. Clyde M. Collins, Contributing Editor; (6) Dr. Richard J. Feinstein, Contributing Editor; (7) Dr. James K. Conn, Assistant Editor; (8) Gerold L. Schiebler, Assistant Editor; (9) Dr. Lee A. Fischer, Associate Editor; (10) Dr. William M. Straight, Contributing Editor.

Second House of Delegates

The Second House of Delegates convened at 1:30 p.m. Saturday, September 20, 1986 in the Regency East/South Room of the Diplomat Hotel, Hollywood, Florida, with Guy T. Selander, M.D., Speaker of the House, presiding.

Dr. Kenneth C. Kiehl, Chairman of the Credentials Committee, reported that 248 Delegates were present with 36 component county societies represented, constituting a quorum, and moved that the Delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Mark V. Barrow, M.D.; Thomas D. Bartley, M.D.; Robert K. Casey, M.D.; James O. Dailey, M.D.; J. Lee Dockery, M.D.; Thomas H. Moore Jr., M.D. (Absent — Mr. Manuel R. Padron, Student Delegate)

BAY — James T. Cook III, M.D.; Ted R. Wilson, M.D. (Absent — Stephen J. Toner, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D.; Richard I. Barr, M.D.; Glenn E. Bryan, M.D.; Onofre P. Carrillo, M.D.; Brian J. Ellis, M.D.; Robert C. Ufferman, M.D.; Joseph C. Von Thron, M.D.

BROWARD — Leroy G. Appell, M.D.; Anna M. Blenke, M.D.; Bruce B. Burgess, M.D.; Andre S. Capi, M.D.; Ernest Costantino, M.D.; George T. Edwards, M.D.; Ronald B. Fauer, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; James A. Jordan, M.D.; Rolando Jorge, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Arthur E. Palamara, M.D.; Ernest G. Sayfie, M.D.; Richard D. Shafron, M.D.; Marvin L. Stein, M.D.; Peter A. Tomasello, M.D.; Dana V. Wallace, M.D.; Alan J. Yesner, M.D.: Nelson R. Zide, M.D. (Absent — David A. D'Allessandro, M.D.; George J. Crane, M.D.; Richard D. Schultz, M.D.; Juan S.A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Terence P. McCoy, M.D. (Absent — Robert N. Webster, M.D.)

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — W. Randall Jenkins, M.D.; Samuel R. Miller, M.D.

CLAY — Charles E. Phillips, M.D.; (Absent — Darrel W. Wyatt, M.D.)

COLLIER — Charles S. Eytel, M.D.; Donald W. Ketterhagen, M.D.; Virgil A. Ponzoli Jr., M.D.

COLUMBIA — Najunda Swamy, M.D.

DADE — Edward R. Annis, M.D.; Jerome Benson, M.D.; Pedro P. Bosch, M.D.; Robert E. Boyett, M.D.; James W. Bridges, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Joseph H. Davis, M.D.; Barbara S. Drabkin, M.D.; Charles A. Dunn, M.D.; Edward J. Feller, M.D.; Miguel Figueroa, M.D.; Bernard J. Fogel, M.D.; Humberto L. Fontana, M.D.; Simon J.H. Frank, M.D.; N. Ralph Frankel, M.D.; Richard L. Glatzer, M.D.; Paul A. Gluck, M.D.; James J. Hutson, M.D.; Norman M. Kenyon, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda A. Marraccini, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto, M.D.; William I. Roth, M.D.; Bruce S. Saltzman, M.D.; A. Frederick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C.S. Skinner, M.D.; Marvin B. Slotkin, M.D.; Leon Suissa, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Steven M. Weissberg, M.D.; Bruce W. Weissman, M.D.; Leo Whitman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; Mr. George David Markovich, Student Delegate (Absent — Manuel Abella-Fernandez, M.D.; Carlos L. Abraira, M.D.; Allen Baumal, M.D.; Harlan S. Chiron, M.D.; B. David Epstein, M.D.; Denio D. Fonseca, M.D.; Enrique L. Gomez, M.D.; Pedro A. Ramos, M.D.; Ruben Urrutia-Carpio, M.D.)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Gaston J. Acosta-Rua, M.D.; Merrill Anderson, M.D.; Clyde M. Collins, M.D.; Patricia C. Cowdery, M.D.; Wilbert L. Dawkins, M.D.; Joseph Foley, M.D.; Walter A. Harman, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; Marc D. Kaye, M.D.; John F. Lovejoy Jr., M.D.; Charles B. McIntosh, M.D.; Kevin M. McAuliffe, M.D.; Sanford A. Mullen, M.D.; Kurt W. Mori, M.D.; David H. Ogburn, M.D.; W. D. Walklett, M.D.; H. Warner Webb, M.D.; C. Davis Whechel III, M.D. (Absent — James H. Corwin II, M.D.)

ESCAMBIA — Paul T. Baroco, M.D.; Eric F. Geiger, M.D.; Everett S. Havard, M.D.; Charles J. Kahn, M.D.; James M. Potter, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson Jr., M.D.

FLAGLER — (Absent — John M. Canakaris, M.D.)

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Richard G. Spindler, M.D. (Absent — Eustus Nelson, M.D.)

HILLSBOROUGH — Miguel R. Alonso, M.D.; Pierre J. Bouis Jr., M.D.; William T. Branch, M.D.; Lawrence S. Cohen, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; Mutaz Habal, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Waite S. Kirkconnell,

M.D.; Victor H. Knight Jr., M.D.; Ralph E. Rydell, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; Mr. Chris Centeno, Student Delegate (Absent — Thomas E. McKell, M.D.; Robert E. McCammon, M.D.; Ronald L. Seeley, M.D.)

INDIAN RIVER — Donald L. Ames, M.D.; Paul A. Graham, M.D.; Michael B. Zimmer, M.D.

LAKE — John L. Geeslin, M.D.; Joseph E. Holland, M.D. (Absent — William H. Shutze, M.D.)

LEE — William R. Bess Jr., M.D.; Robert J. Brueck, M.D.; Larry P. Garrett, M.D.; F. Lee Howington, M.D.; T. T. Knight, M.D.; Marcus M. Moore, M.D.; Douglas A. Newland, M.D.

MADISON — M. Linda Dulay, M.D.

MANATEE — Thomas R. Busard, M.D.; Gary L. Dunlap, M.D.; Julian Giraldo, M.D.; George R. McSwain, M.D. (Absent — Gerald G. Whitt, M.D.)

MARION — Henry L. Harrell Jr., M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D. (Absent — James M. Hayes, M.D.)

MONROE — Ronald H. Chase, M.D.

NASSAU — (Absent — Cecil B. Brewton, M.D.)

OKALOOSA — William W. Thompson, M.D. (Absent — David R. Arrowsmith, M.D.)

ORANGE — Richard J. Bagby, M.D.; Henry J. Baskin, M.D.; Clarence H. Brown III, M.D.; Manuel J. Coto, M.D.; Wayne L. Godbold, M.D.; Jay M. Hughes, M.D.; Angelo Massaro, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Calvin R. Peters, M.D.; Wallace M. Philips Jr., M.D.; James F. Richards Jr., M.D.; Philip N. Styne, M.D.; Thomas B. Thames, M.D.; Cecil B. Wilson, M.D. (Absent — David L. Mackey, M.D.)

OSCEOLA — Alonzo J. Logan, M.D.; Gilberto Perez, M.D.

PALM BEACH — Joe A. Baker, M.D.; E. Joan Barice, M.D.; Richard C. Cavanagh, M.D.; McKinley Cheshire, M.D.; Tommy M. Coffman, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; V. A. Marks, M.D.; R. Benjamin Moore, M.D.; Gilbert R. Panzer, M.D.; William J. Romanos Jr., M.D.; Joel F. Smith, M.D.; Anthony L. Thebaut, M.D.; Milton R. Tignor, M.D.; Dick L. Van Eldik, M.D. (Absent — James D. Daughtry, M.D.; Myron M. Persoff, M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony P. Garritano, M.D.; William E. Hale, M.D.; John M. Hamilton, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris LeVine, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Jack N. Rothman, M.D.; Bruce P. Smith, M.D.; James L. West, M.D. (Absent — William H. Schmid, M.D.)

POLK — Annette C. Barnes, M.D.; Francis D. Drake, M.D.; Richard M. Garcia, M.D.; John W. Glotfelty, M.D.; David T. Jones, M.D.; Thomas E. McMicken, M.D.; Robert B. Peddy, M.D. (Absent — Henry M. Haire, M.D.; Dale L. Taylor, M.D.)

PUTNAM — Roy E. Campbell, M.D.

ST. LUCIE-OKEECHOBEE — Manuel Garcia, M.D.; Khalil Cassimally, M.D. (Absent — David L. Fromang, M.D.)

SANTA ROSA — David B. Young, M.D.

SARASOTA — William E. Bush, M.D.; John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Charles R. Mathews, M.D.; Franklin H. Pfeiffenberger, M.D.; Karl R. Rolls, M.D.; Ernest C. Smith, M.D.; Phyllis A. Stephenson, M.D.; David L. Thomas, M.D.

SEMINOLE — Humberto A. Dominguez, M.D.; Robert Gay, M.D.; James E. Quinn, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Andrew C. Bass, M.D.)

TAYLOR — (Absent — John H. Parker, M.D.)

VOLUSIA — H. Frank Farmer Jr., M.D.; Richard Huster, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.; H.S.B. Treloar, M.D.

WALTON — (Absent)

WASHINGTON — (Absent)

SPEAKER OF HOUSE — Guy T. Selander, M.D.

VICE SPEAKER — Arthur L. Eberly, M.D.

MEMBER APPOINTED FROM THE HOSPITAL MEDICAL STAFFS COUNCIL — Raymond F. Barnes, M.D.

SPECIALTY GROUP DELEGATES

ALLERGY AND IMMUNOLOGY, SOC. FLA. — Melvin Newman, M.D.

ANESTHESIOLOGISTS, FLA. SOC. OF — Jimmie D. Moore, M.D.

DERMATOLOGY, FLA. SOC. OF — Clifford Lober, M.D.

FAMILY PHYSICIANS, FLA. ACADEMY OF — Donald Twiggs, M.D.

INTERNAL MEDICINE, FLA. SOC. OF — Robert Meade, M.D.

PATHOLOGISTS, FLA. SOC. OF — Jerry L. Harris, M.D.

PEDIATRIC SURGEONS, FLA. ASSN. OF — Malvin Weinberger, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEONS, FLA. SOC. OF — John S. Bruno, M.D.

PREVENTIVE MEDICINE, FLA. SOC. FOR — Donald S. Kwalick, M.D.

PSYCHIATRIC ASSN., CO. OF FLA. DIST. BRANCHES OF THE AMERICAN — George W. Metcalf, M.D.

SURGEONS, FLA. ASSN. OF GENERAL — Michael J. Foley, M.D.

SPECIALTY GROUPS WITH NO DELEGATE REPRESENTATION PRESENT AT SECOND HOUSE

Chest Physicians, Amer. Coll. of, Fla. Chapter
Colon and Rectal Surgeons, Fla. Soc. of
Emergency Physicians, Am Coll. of, Fla. Chap.
Endocrine Society, Fla.

Gastroenterologic Soc., Fla.
Neonatal Perinatologists, Fla. Soc. of
Nephrology, Fla. Soc. of
Neurology, Fla. Soc. of
Neurosurgical Society, Fla.
Nuclear Physicians, Fla. Assn. of
Obstetric & Gynecologic Soc., Fla.
Occupational Medical Assn., Fla.
Oncology, Fla. Soc. of Clinical
Ophthalmology, Fla. Soc. of
Orthopedic Society, Fla.
Otolaryngology, Head & Neck Sur., Fla. Soc. of
Pediatric Cardiologists, Fla. Assn. of
Pediatric Soc., Fla., and Pediatrics, American Academy, Fla. Chapter
Physical Medicine and Rehab., Fla. Soc. of
Physicians, American College of, Fla. Region
Radiological Society, Fla.
Rheumatology, Fla. Soc. of
Surgeons, Amer. College of, Fla. Chapter
Surgeons, International College of, Fla. State Surgical Division
Thoracic and Cardiovascular Surgeons, Fla. Soc. of
Thoracic Society, Fla.
Urological Society, Fla.

Dr. Selander requested that Dr. Perez make the announcements and introductions. Dr. Perez introduced Mrs. Susan Marks, President, Florida Medical Association Auxiliary, and she addressed the House.

Dr. Perez introduced Mrs. Jo Tignor, Immediate Past President, Florida Medical Association Auxiliary. Mrs. Tignor presented to Dr. Perry a check for $13,980.50 for the Florida Medical Foundation. Mrs. Tignor recognized Florida's three medical schools who received checks earlier in the year from AMA Educational Research Foundation totaling $59,334.89.

Dr. Perez recognized Mr. Fred B. Hagan, Chairman, Florida Coalition for Liability Reform, who addressed the House on the success of the Coalition.

Dr. Selander recognized Dr. Louis Murray who encouraged the House to write letters to Senator Lawton Chiles on medical budget reconciliation.

Dr. Charles P. Hayes Jr., on the behalf of the Duval County Delegation, moved that all incumbents of the Board, Officers and AMA Delegates and Alternates that are running without opposition be elected unanimously by the House of Delegates without the need for nominating and seconding speeches. The motion carried.

The order in which the Reference Committee Reports appear in the Proceedings is the order that the House business was conducted. Reference Committee reports will appear in the following order: Second House — REference Committee No. III, Finance and Administration; Third House — Reference Committee No. II, Public Policy; Reference Committee No. I, Health and Education; Reference Committee No. IV, Legislatin and Miscellaneous; Reference Committee No. V, Medical Economics.







(A) Mrs. Jo Tignor, FMA-A President, presents the AMA-ERF check to Dr. Richard G. Connar, on behalf of the University of South Florida College of Medicine. (B) Mrs. Jo Tignor, FMA-A President, presents the AMA-ERF check to Dr. J. Lee Dockery, on behalf of the University of Florida College of Medicine. (C) Mrs. Jo Tignor, FMA-A President, presents the AMA-ERF check to Dr. Bernard Fogel, on behalf of the University of Miami School of Medicine.

Report of Reference Committee No. III Finance and Administration

Dr. Selander called the Chairman and members of Reference Committee No. III, Finance and Administration, to present their report.

Dr. Norman Kenyon, Chairman, and his Committee came forward to present their report of Reference Committee III, Finance and Administration.

Remarks of the Speaker of the House

Dr. Kenyon expressed his Committee's wish to commend Dr. Selander for the clear and precise rules under which the House of Delegates acts and his summary given at the beginning of the meeting.

The Remarks of the Speaker presented at the First House of Delegates were adopted as presented (See page 932, First House of Delegates).

President's Address

Dr. Kenyon expressed his Committee's wish to commend Dr. Perez for his outstanding leadership on behalf of the members of the Association for the past year and four months.

The President's Address presented at the First Meeting of the House of Delegates was adopted as presented (See President's Address, page 927).

Florida AMA Delegation

Dr. Kenyon expressed his Committee's wish to commend the entire Florida AMA Delegation for its outstanding representation of the physicians of Florida in the AMA House of Delegates in establishing national health policy.

The Report of the Florida AMA Delegation was adopted as presented.

Florida AMA Delegation

Charles K. Donegan, M.D., Chairman

It has again been a pleasure to serve as Chairman of your Florida AMA Delegation during the past year, ably assisted by our Vice Chairman, Joseph C. Von Thron, M.D.

The effectiveness and influence of our delegation nationally is due to the time and effort given freely by your delegates and alternate delegates. Appreciation must go to:

Delegates	Alternates
Joseph C. Von Thron, M.D.	James B. Perry, M.D.
T. Byron Thames, M.D.	Lee A. Fischer, M.D.
Joseph T. Ostroski, M.D.	Eugene G. Peek Jr., M.D.
Richard A. Connar, M.D.	O. William Davenport, M.D.
Louis C. Murray, M.D.	Charles A. Dunn, M.D.
Luis M. Perez, M.D.	Alvin A. Smith, M.D.
Sanford A. Mullen, M.D.	Daniel L. Seckinger, M.D.
J. Lee Dockery, M.D.	Arthur L. Eberly, M.D.
Frank C. Coleman, M.D.	Dick Van Eldik, M.D.
Charles J. Kahn, M.D.	Henry M. Yonge, M.D.
Kay K. Hanley, M.D.	

We are pleased that our caucuses included delegates from Puerto Rico, Fernando J. Cabrera, M.D. and Emilio Arce, M.D.; the delegates from the Virgin Islands, Andre Galiber, M.D., and Howard E. Hill, M.D.; and the delegate from Guam, Dennis Harston, M.D.

The AMA was again faced with a year filled with a broad range of controversial issues. As the FMA Annual Meeting was changed to September 1986, this report includes AMA actions taken at the 1985 AMA Annual Meeting, 1985 Interim Meeting, and 1986 Annual Meeting. The activities of your delegation have been regularly reported to the FMA Board of Governors and the FMA membership through various Association publications.

A. **Southeastern Delegation:** Your delegation continued to participate in the Southeastern Delegation which is composed of the following states:

Alabama	Maryland
Delaware	Mississippi
District of Columbia	North Carolina
Florida	South Carolina
Georgia	Virginia
Louisiana	

B. **Resolution:** The Florida Delegation introduced a resolution at the AMA Interim Meeting calling for an AMA Coalition for Tort Reform. This resolution was referred to the Board of Trustees. It requested that the AMA work to establish a formal joint coalition for tort reform to formulate initiatives for consideration of proposals for alternative mechanisms to the current tort system for settling medical malpractice and other liability disputes, and recommended that the initiatives developed be implemented at the state level and supported by a major comprehensive public educational campaign at the national level.

The following is a summary of other major actions taken by the AMA House of Delegates:

C. **1985 AMA Annual Meeting**

1. **Medicare Programs**

Report EE of the Board of Trustees was a brief report on studies of the fiscal stability of Medicare, which informed the House that it is studying the development of a Health



Reference Committee No. III (Finance and Administration) was chaired by Norman Kenyon, M.D., Miami. Left to right: Charles J. Kahn, M.D., Pensacola; Richard J. Bagby, M.D., Winter Park; Kevin M. McAuliffe, M.D. Jacksonville; Ms. Lynn Mobarak, Recorder; Dr. Kenyon; Calvin W. Martin, M.D. Arcadia; Robert R. Eastridge, M.D., Palm Beach Gardens; Harold L. Ishler, M.D., Clearwater.

IRA proposal to improve the programs financial soundness. Resolution 16, "Health IRAs" and Resolution 89, "Endorsement of IRAs," both call for the conditional support by the Association of Health-IRAs. The House adopted these Resolutions.

Resolution 18, "Direct Provided Payment for All Medicare Medical Services" was adopted by the House. This Resolution asks that the Association seek direct payment to providers by Medicare whether or not the provider accepts assignment. There was considerable debate on this Resolution because it would require a change in the law, not merely in regulations.

Resolution 38, "Capitation Programs for Medicare Recipients" was adopted. This Resolution calls for regulations which would require Health Maintenance Organizations and Competitive Medical Plans to fully explain ramifications of membership to Medicare eligibles and for HHS to verify performance capabilities of such plans before awarding them contracts.

The House adopted Substitute Resolution 110 which concerns Medicare Payments. The Resolution states:

RESOLVED, That the American Medical Association requests that the Health Care Financing Administration direct Medicare carriers in each state to re-evaluate the data and methodology used in calculating customary profiles in the local prevailing fee screens for all physicians, and that these customary charge profiles be made available promptly to each physician, when requested, for review and verification, and be it further

RESOLVED, That the American Medical Association continue its opposition to the limitations on increases in the customary and prevailing charge levels for Medicare reimbursement and its opposition to the freeze on actual fees for services provided Medicare beneficiaries.

2. **Health Care Funding for the Financially Disadvantaged**
 Report A of the Council on Medical Services entitled "Closing the Gaps in Health Care Funding" was adopted by the House. This is a detailed report on the amount of uncompensated care provided by physicians, the types and estimated number of patients receiving such care, and potential solutions. It was further recommended that this report receive wide dissemination, especially through AMA media sources. This subject is of critical importance that requires continued study and future reports regarding the issues of financing coverage and availability of adequate health expense coverage.

3. **Professional Liability**
 The House approved two reports on the Association's activities in Professional Liability. Report OO is a report by the Committee on Professional Liability on its study of professional liability plaguing obstetricians and gynecologists and Florida physicians which recognizes that both groups are facing a special crisis involving both affordability and availability of professional liability coverage.

 Report AA details the program of the Association's Special Task Force on Professional Liability and Insurance, and many activities undertaken in implementation of the Action Plan to date.

 Two other Resolutions were adopted by the House concerning the malpractice crisis. Resolution 149, entitled the "Malpractice Crisis" directs the AMA Board of Trustees to urge the Special Task Force on Professional Liability and Insurance to consider all means to inform the general public concerning the malpractice crisis. It also urges an AMA appeal to the Federal Government and local medical society appeals to state legislators and governors, to propose solutions to the professional liability situation.

 Resolution 155, entitled "Liability Media Campaign," directs the AMA immediately to begin preparation of an expanded and more specific response to the American Trial Lawyers Association regarding the current situation in professional liability and to make the resulting rebuttal to ATLA contentions available for use by advocates of Tort Reform to counter and dispel ATLA's arguments before the public. The Resolution was amended to reflect the fact that the Association has already begun developing a response to the ATLA's arguments.

4. **Alternative Delivery Systems**
 The House of Delegates considered and adopted several Resolutions relating to Alternative Delivery Systems including Resolution No. 54 presented by the Florida Delegation. This Resolution was combined into Substitute Resolution No. 43. It calls for legislation to revise federal policies so that employers must make traditional

fee-for-service coverage as an option to employees whenever employers are mandated by law to offer an HMO option for health care services.

The House also adopted Resolution 90, "Medical Society Sponsorship of Statewide IPA/HMO." This Resolution calls for the AMA to monitor the Medical Association of Georgia Independent Practice Association/HMO Plan and determine if its widespread use would be beneficial. The House also reaffirms support for the indemnity payment system and will seek immediate implementation of it at the national level.

5. **Peer Review Organizations**
Report H of the Council on Medical Services reported on the status of the Peer Review Organization (PRO) Program. The Council concluded that the current Association policy on Peer Review remains appropriate but that it should be continually reassessed in light of new developments in the PRO program. Testimony reviewed also indicated some specific problems with the PRO Program, such as some PROs' establishment of standards of care in medical protocols without the appropriate involvement of practicing physicians. These matters will be included in future council studies. Resolution 105, "PRO Appeals Process" was adopted by the House. This Resolution favors changing federal legislation to allow physicians access to an administrative hearing or judicial review of an unfavorable reconsidered decision by a PRO.

D. **1985 Interim Meeting**

1. **Tobacco Products**
Resolution 90 — Smokeless Tobacco — was adopted and called upon the AMA to oppose the use of smokeless tobacco, support warning labels for smokeless tobacco, seek prohibition of sale of such products to minors, seek prohibition of television advertising of smokeless tobacco, and inform the public of the health risks of using these products.

Resolution 109 — Tobacco Product Sales — was adopted and requested that the AMA draft model legislation prohibiting vending machine sales of cigarettes, work for legislation making 21 the legal age for purchasing tobacco products, and urge strict enforcement of laws prohibiting sales of tobacco products to minors.

Resolution 60 — Tobacco-free Society by 2000 — was adopted and asked that the AMA include smokeless tobacco products in its educational and legislative campaigns against smoking, and that the goal of a smoke-free society by the year 2000 be enlarged to a tobacco-free society by the year 2000.

2. **Reporting of Incidents**
Resolution 120 was adopted as amended and called upon the AMA to adopt a three-point policy that: 1) all hospital reports required by states or other outside authorities involving individual physician care of patients should be reviewed by an appropriate medical staff committee prior to reporting; 2) hospital medical staffs should be given a reasonable amount of time to evaluate any reports pertaining to a physician's care of patients; and 3) the organized medical staff should seek the assurance of the state agency or outside authority that the report will not be subject to public disclosure.

The House of Delegates amended Resolution 120 to read as follows:

RESOLVED, That the American Medical Association adopt as policy that:

a. All hospital reports mandated by state agencies or outside authorities involving individual physician care of patients should be reviewed by an appropriate medical staff committee prior to reporting;
b. Hospital medical staffs be given a reasonable period of time to evaluate any reports pertaining to a physician's care of patients;
c. The organized medical staff should seek the assurance of the state agency or outside authority that the report will remain strictly confidential.

3. **Resident Physician Training**
Resolution 30 was adopted as amended and calls upon the AMA to support continued funding for residency training so that housestaff currently in training programs should not have their positions eliminated for reasons of cost containment only.

The House of Delegates amended Resolution 30 to read as follows:

RESOLVED, That the American Medical Association advocate continued funding for residency training so that housestaff currently in training programs should not have their positions eliminated for reasons of cost containment only.

4. **Medicare Fee Freeze**
Resolution 31 was adopted and asked the AMA Board of Trustees to report to the House of Delegates on whether the membership at large believed the Medicare fee freeze to be a significant issue and whether individual members responded to the Association's request that they contact their U.S. Representatives, and to suggest what, if any, mechanisms should be implemented to strengthen liaison between the AMA leadership, state and county medical societies, and individual members.

5. **Peer Review of the Performance of Hospital Medical Staff Physicians**
Resolution 57 was adopted and asked that the AMA encourage objective peer review of the performance of hospital medical staff physicians, and study the feasibility of establishing a system of outside peer review of hospital medical staff performance.
The House of Delegates amended Resolution 57 to read as follows:

RESOLVED, That it is the policy of the American Medical Association to encourage peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians; and be it further

RESOLVED, That the AMA study the appropriateness, legal implications and indications of outside peer review of hospital medical staff performance utilizing the services of physicians other than the hospital's own organized medical staff.

6. **Payment for Physician Services Under Medicare**
Resolution 71 was adopted as amended and called upon the AMA to support the position that payment for physician services under the Medicare program should include an idemnity system based on a defined schedule of allowances.

The House of Delegates amended Resolution 71 by substituting the following for point 1, "be based on a realistic resource cost relative value scale." Resolution 71 reads as follows:

RESOLVED, That the American Medical Association support the position that payment for physician services under the Medicare program should include an indemnity system based on a defined schedule of allowances that would; 1) be based on a realistic resource cost relative value scale; 2) allow appropriate regional differences in allowances to reflect differences in the costs of practice; and 3) would indemnify patients for covered services, maintaining the rights of physicians and patients to enter into individual contracts wherein physicians establish their own fees and agree or not agree to accept amounts identified by the schedule of allowances as payment in full.

7. **HCFA and Physician Payment**
Resolution 114 was adopted and called upon the AMA to urge the Health Care Financing Administration to halt the retrospective denial of payment until all interested parties have an opportunity to speak to the issue and to develop new guidelines that will be equitable to all interested parties, and asked that the AMA support legislation that would provide hearing rights for physicians and beneficiaries in cases of retrospective denial.

E. **1986 AMA Annual Meeting**

1. **Section on Young Physicians**
Report FF was adopted pertaining to Young Physicians in Organized Medicine. The report as adopted included the recommendation that a special section for young physicians be created to be composed of all active physician members of the AMA who are not serving in an approved resident training program, but who are under 40 years of age or are within the first five years of professional practice after residency.

2. **Professional Liability**
The Board of Trustees Report of the Special Task Force on Professional Liability and Insurance was adopted in lieu of several resolutions pertaining to professional liability, inasmuch as the report embraced most of the resolutions, including support for national legislation on this subject. The House adopted Resolution 81 which calls for the AMA to establish a "legal challenges clearinghouse" at the national level to monitor tort reform legal challenges in the various states, their successes or failures, and to make information available to state medical associations when tort reform measures in their state are challenged in court. Resolution 109 was also adopted asking the AMA to actively promote the legal changes necessary to establish "liability courts" which would process liability cases in much the same way that tax courts handle allegations of tax law violations.

3. **Childhood Immunizations**
The Florida delegation was instrumental in providing wording that significantly amended and strengthened a resolution relating to the shortage of vaccine for American youth due to the medical liability insurance crisis. Vaccine manufacturers have cut back on production of certain vaccines because of the constant threat of liability suits and the escalating cost of liability insurance coverage. The resolution calls on Congress to immediately enact tort reform so as to allow for the safety, efficiency and availability of childhood vaccines at a conscionable cost. The shortage has resulted in a sharp increase in prices for vaccines.

4. **Foreign Medical Graduates**
Report T of the Board of Trustees included findings and recommendations of a task force which studied physician manpower and the future supply of physicians. The House also adopted Report C of the Council on Medical Education which included licensure issues and foreign medical graduates; and further adopted a recommendation that the AMA should continue to support the activities of the ECFMG related to verification of education credentials and testing of foreign medical graduates.

5. **Mandatory Medicare Assignment**
Resolution 83 was adopted opposing any mandatory assignment of Medicare to physicians, calling on the AMA to develop a mechanism to bring any necessary expertise and funding to states facing mandatory assignment initiatives or proposed legislation.

6. **Public Health Issues**
Report UU was adopted pertaining to AIDS. The report provides information on: 1) the clinical spectrum of HTLV-III disease; 2) development of an AIDS vaccine; 3) therapy for AIDS; 4) AIDS related viruses; 5) epidemiology of AIDS; and 6) an update on AMA's Action Plan on AIDS. Many recommendations pertaining to smoking and tobacco were also adopted. Of major significance was Resolution 128 calling for a tobacco free society. Resolution 17 concerning physician suicide prevention was adopted with an amendment for the increased availability for alcohol, drug abuse, and mental illness treatment insurance coverage.

F. **AMA Candidates for Elective Office**
The 1986 AMA Annual Meeting concluded the vigorous campaigns of Rufus K. Broadaway, M.D. for President-elect and J. Lee Dockery, M.D. for Council on Medical Education. After a runoff ballot between Dr. Broadaway and William S. Hotchkiss, M.D., Chairman of the AMA Board of Trustees, our candidate lost a strong bid in an extremely close election. Dr. Broadaway, a member of the AMA Board of Trustees and Chairman of the AMA Education and Research Foundation, expressed his gratitude to all delegates who voted for him and for the active support of the Florida Medical Association. Special appreciation must be expressed to Sanford A. Mullen, M.D., who directed the outstanding efforts in Dr. Broadaway's superb campaign. Florida delegates were delighted to contribute to the re-election of Dr. Dockery to the Council on Medical Education. Dr. Dockery will serve his second term after being first elected in 1983.

Committee on Women Physicians

The Report of the Committee on Women Physicians was adopted as presented.

Committee on Women Physicians
Myrna C.B. Ginter, M.D., Chairman

The major project of the Committee on Women Physicians in the first year of its existence was the presentation of the Second Annual Leadership Skills Seminar for Women Physicians. This highly successful program was conducted on January 24 as part of the FMA Leadership Conference in Tampa and attracted 71 attendees. Guest speakers included Supreme Court Justice Rosemary Barkett; Mrs. Sheila Burke, Deputy Chief of Staff to Senate Marjority Leader Robert Dole; Palma Formica, M.D.; State Rep. Betty Easley of Largo; Kay K. Hanley, M.D., of Clearwater; and Rufus K. Broadaway, M.D., of Miami.

The Committee looks forward to arranging and presenting another successful seminar next year.

A new membership recruitment brochure for women physicians, residents and medical students has been approved by the Board of Governors and will be developed soon.

The Committee is interested in getting more women physicians appointed to FMA committees and councils and outside groups for which FMA is asked to submit nominations.

Public Relations Officer

The Reference Committee reviewed with great interest the Report of the FMA's Public Relations Officer, Kay K. Hanley, M.D., regarding the FMA's current and planned activities. The Reference Committee recognized the importance of continuing efforts to enhance this important program and particularly the development of Speakers' training programs for the leadership of component county medical societies. The Committee also noted that the expansion of the FMA's public relations activities was a key factor in the request of the Board of Governors for the increase in FMA dues.

The Report of the Public Relations Officer was adopted as presented.

Public Relations
Kay K. Hanley, M.D., Officer

During 1985-86, the efforts of the FMA Public Relations Program in the area of Communications have been primarily focused on the issues surrounding the professional liability crisis with emphasis on county medical societies, specialty groups, physician members and public education. The Board of Governors felt that an involved and informed membership was the key to our efforts to succeed in bringing about tort reform during the 1986 Legislative Session.

The FMA's internal communications with the membership and county medical societies has been greatly enhanced during the last year. The Board of Governors authorized the publication of *FMA Today*, a tabloid-size monthly newspaper which began publication in September 1985. Reader acceptance of *FMA Today* has been outstanding and the publication's objective of keeping physicians currently informed about pertinent issues affecting medicine is being met.

Another internal publication, *E.T., (Every Thursday)*, is also enjoying high readership acceptance. *E.T.* is a weekly newsletter which is sent to officers, county medical society and specialty group executive directors, and members of the Board of Governors. County medical societies are urged to duplicate *E.T.* for distribution to their county medical society leadership.

The FMA is currently studying ways by which the Association within its financial capabilities can address the issue of the physician's image. The public communications for the coming year will continue to be focused on the professional liability issue. However, improving the physician's image will also be major priority. A major part of this effort will include emphasis on FMA and county medical society activities relative to those issues regarding the cost and quality of health care, indigent health care, ethics and discipline, and other timely issues that mold public opinion.

Another goal is to develop in cooperation with component county medical societies a continuing speaker's training program for physicians who represent the FMA and county medical societies before state and local public forums.

The FMA Board of Governors has approved in principle a number of important programs and activities to be carried out within the Association's financial capabilities. These include:

1. Establishment of a viable working relationship with key medical writers on each major daily newspaper.
2. Increased emphasis on editorial visitations regarding issues affecting the public's health and issues of concern to medicine.
3. Consideration of the establishment of an 800 call-in number with prerecorded health hints and messages (to be updated as necessary).
4. Continue efforts to build alliances with both health related organizations and business industry to address health issues.
5. Development of community outreach programs in cooperation with local county medical societies.
6. Consideration of a television master program for county adaptation to be held semi-annually or annually.

The following are some of the highlights of additional FMA public relations activities which have been carried out during the 1985-86 Association year:

1. ***FMA Today*** has been published monthly since September, 1985.
2. ***E.T.*** has been published weekly.
3. ***Medical Messages*** continues to be published and mailed to Florida's newspapers on a monthly basis.
4. ***Health Notes for Older Adults:*** This column is published monthly. In addition to newspapers, it is also sent to many retirement homes which have internal newsletters. Readership of the column is excellent. Several letters of thanks have been received by the Communications Department for providing this column.
5. **News Releases:** News releases have been issued during the past year to make FMA's position on various issues known to all the media in Florida.
6. **Media Inquiries:** Answering media inquiries promptly is an important function of the FMA Communications Department. Approximately 15 to 20 calls are received each month. FMA President, Luis M. Perez, M.D., as chief spokesperson for FMA, has done an outstanding job in discussing issues with the news media. In addition, Dr. Perez and other FMA representatives have appeared on several television programs across the state and at the national level.
7. **Speakers Training:** A high priority in the coming months will be the development of effective speakers training for physicians who serve on county medical society speaker bureaus. A successful pilot program was held in February for approximately 15 physicians in Duval County. Efforts are being made to schedule speakers training courses for members of the FMA Board of Governors and other physicians who represent the FMA and county medical societies before various public forums.
8. **Communications Support for "The Assembly for Liability Reform":** Approximately twenty news organizations sent reporters to Tallahassee to cover "The Assembly for Liability Reform" on April 21. Stories were carried by virtually every newspaper, radio, and television station in the state.

 For the Assembly, the FMA Communications Department produced or assisted in the design and production for statewide use posters, newspaper ads, an extensive brochure, news releases and press kits. Several other states have subsequently requested permission to use FMA promotional materials and professional liability activities in their states. The FMA received many accolades from other members of the Coalition regarding not only the production of the promotional and educational materials that were utilized during the Assembly but also the superb organization of the entire activity.
9. **Awards:** The Medical Journalism Awards, established to encourage excellence in medical reporting by both electronic and print media, was conducted again this year and awards will be presented at the Annual Meeting. The Medical Speakers and the Medical Malpractice Prevention Awards programs also were continued.
10. **Informed Parents:** At its meeting in February, the Board of Governors approved in principle the FMA's support and financial

assistance to the Florida Informed Parents, Inc., for their educational programs on drug abuse for adolescents and teenagers and left to the discretion of the FMA Executive Committee the level of FMA financial assistance pending further clarification of the overall budget of the organization in relation to the financial contribution being requested from the FMA, the level of physician involvement, and the scope of activities in which the FMA would be involved. These questions were subsequently clarified and the Executive Committee authorized funds up to the amount of $10,000 to assist the group in this educational activity in the form of in-kind printing services through Centurian Press. As your Public Relations Officer, I am pleased to represent you as a member-at-large on the Board of Directors of Florida Informed Parents, Inc. In addition, Dr. Joseph Deatsch, Chairman of the FMA Substance Abuse Committee, serves on the Advisory Board, Mrs. Bennie Spanjers serves on the Board of Directors and Mrs. Priscilla Gerber serves on the Advisory Board. The FMA's participation in the important activity is one of the most worthwhile projects in which the FMA can participate, from a public relations standpoint.

Committee on Membership Development

The Reference Committee appreciated the efforts of Charles K. Donegan, M.D., Chairman, Committee on Membership Development.

The Report of the Committee on Membership Development was adopted as presented.

Committee on Membership Development
Charles K. Donegan, M.D., Chairman

Membership recruitment and retention should be a matter of concern to all Florida Medical Association members and a priority project of all component county medical societies. The Committee on Membership Development is pleased to note that as a result of efforts by the Committee, peer-to-peer contacts by FMA members and programs of county medical societies, FMA membership is at least holding firm and Florida membership in the American Medical Association reached a new high during the past year.

Membership gains as well as important activities of the Committee since the 1985 Annual Meeting are discussed under appropriate headings below:

1. **FMA Membership:** On May 12, 1986, FMA membership stood at a total of 14,750 in all categories which represents a 2% increase over the 1985 official membership census taken on December 31, 1985. Virtually the entire increase was in dues-paying categories (active and associate members) which increased from 12,632 in 1985 to 12,915 in May of 1986.

 The May 12 figures in each category were: Regular Active, 11,562; Provisional, 1,097; Associate, 85; Resident, 129; Student, 42; Life Members, 694; Honorary, 3; and Other Dues Exempt, 1,138.

 These figures no doubt will change by the time the official membership count for 1986 is taken on December 31. There will be an indefinite number of drops due to resignation or non-payment of dues. These could be offset or overridden by admission of new members. FMA's 1986 legislative program as well as group and individual membership recruitment and retention efforts in the coming months no doubt impact heavily on the final net result.
2. **AMA Membership:** During calendar year 1985, we had a spectacular gain of almost 900 AMA members from Florida, thus entitling the FMA to its 12th seat in the AMA House of Delegates. As of December 31, 1985, Florida had a total of 11,601 dues paid and dues exempt AMA members, compared with 10,706 in 1984.

 Florida is seventh among the states in total AMA membership but only 38th in the percentage of FMA members who are AMA members. Forty-four percent of all FMA members are not members of the AMA.
3. **Status of Committee:** Your Committee is pleased that upon recommendation of the Executive Committee, the Board of Governors has approved the designation of the Committee on Membership Development as a standing committee of the Association to be provided for in the bylaws. This action underscores the importance and critical nature of the Committee's mission.
4. **Local Membership Development Committees:** Despite an intense effort to encourage county medical societies to establish local membership development committees, less than half have done so. The following county societies have advised the Committee that such local committees have been formed or that membership development activities are assigned to some existing committee: Brevard; Broward; Charlotte; Citrus; Clay; Dade; DeSoto-Hardee-Glades; Escambia; Franklin-Gulf; Hillsborough; Lake; Lee; Manatee; Martin; Orange; Palm Beach; Pasco; Sarasota; Seminole; Suwannee-Hamilton-Lafayette; and Volusia.
5. **Membership Development Workshop:** With the approval of the Board of Governors, the Committee arranged, in cooperation with the AMA, a one-day membership recruitment and retention workshop for August 8, 1986, in Tampa. Faculty included your Chairman, Committee member Sanford A. Mullen, M.D., of Jacksonville, and members of the AMA membership development staff. Members of local membership development committees, as well as county executives and officers were invited.
6. **Membership Phonathon:** On May 20-21, the FMA in cooperation with the Dade County Medical Association and the AMA, conducted its first Membership Recruitment Phonathon. Fifteen volunteer physicians manned telephones in two-hour shifts at the DCMA headquarters. They reported 97 completed telephone calls. Forty-one of the nonmember physicians called indicated they would join DCMA/FMA and/or the AMA.

 Three other physicians volunteered to make calls later from their offices. The results of those efforts plus follow-ups on non-completed calls placed during phonathon hours no doubt will increase the number of completed calls and membership pledges somewhat.

 The program will be evaluated in terms of the number of coded membership applications completed and returned to DCMA.
7. **1986 Medical School Graduates:** This summer, 338 members of the nation's 1986 medical school graduating classes began residency training at Florida institutions under the 1986 matching programs. The new physicians are training at All Children's Hospital, St. Petersburg; Bayfront Medical Center, St. Petersburg; Florida Hospital, Orlando; Halifax Hospital Medical Center, Daytona Beach; Jackson Memorial Hospital, Miami; Jacksonville Health Education Program; Miami Children's Hospital; Mount Sinai Medical Center, Miami Beach; Orlando Regional Medical Center; Pensacola Educational Program; Tallahassee Memorial Regional Medical Center; University of Florida Affiliated Hospitals; and University of South Florida Affiliated Hospitals.

 On May 1, FMA President Luis M. Perez, M.D., sent a letter to each of these new physicians. In most cases, the letters reached the new graduates before they departed their medical school locus. As of June 10, 85 students filled out and returned a business reply card expressing an interest in joining organized medicine in Florida, a response rate of slightly over 20%.
8. **Medical School and Residency Orientation Programs:** In early March, the Committee directed a letter to Florida's three medical schools and the residency programs mentioned in Item 7 above seeking time on orientation programs in order to present

organized medicine to first-year medical students and residents. Most of the institutions either did not respond or declined to allot time on the ground that their orientation agendas are full.

However, arrangements have been made in cooperation with the appropriate county medical societies to have organized medicine represented at orientation programs for first-year residents at Mount Sinai Medical Center in Miami Beach; Orlando Regional Medical Center in Orlando; and Tampa General Hospital in Tampa.

In addition, the Committee is working with the Hillsborough County Medical Association to develop a special program for first-year students at the University of South Florida College of Medicine in Tampa.

9. **New Membership Brochure:** A new FMA membership development brochure went into service in June. It replaced three separate brochures aimed at practicing physicians, residents and students.

10. **AMA Invitation to Join Program:** For the third consecutive year, the Committee, with the authorization of the Board of Governors, cooperated in the "Invitation to Join" Program. A mailing consisting of cover letter and both AMA and FMA membership brochures was sent in June to approximately 5,400 practicing physicians and residents-in-training who, according to AMA records, are not members of organized medicine at any level. The program will be evaluated through follow-up over the coming months on coded return cards requesting additional information about membership.

11. **FMA/CMS Membership Application Project:** Again, with the authorization of the Board of Governors, the Committee has offered to mail membership applications to new arrivals in Florida for county medical societies that wish it to do so. The AMA supplies FMA on a weekly basis what is known as a physician movement report.

 Drawn from the AMA master file, this report notes name changes of Florida physicians due to marriage and other reasons, movement of physicians from one Florida county to another, from Florida to another state and from another state to Florida. Under this program, each physician in the latter category will get a personal letter from the FMA president welcoming him or her to Florida and extending an invitation to join organized medicine. Each letter will contain the name, address and telephone number of the local county medical society executive. Each piece of mail also will include an FMA archives form and membership brochure and the participating county medical society's membership application.

 As of June 12, participating counties included Broward, Pasco, Panhandle, Citrus, DeSoto-Hardee-Glades, Sarasota, Walton, Charlotte, Lee, Osceola, Seminole, Palm Beach and Hillsborough.

 As of May 28, participating counties included Broward, Pasco, Panhandle, Citrus, DeSoto-Hardee-Glades, Sarasota, Walton, Charlotte, Lee, Osceola and Seminole.

Judicial Council

The Report of the Judicial Council was adopted as presented.

Judicial Council
Joseph H. Davis, M.D., Chairman

The 1986 Annual Report of the Judicial Council will summarize the Council activities since the May 1985 Annual Meeting of the Florida Medical Association. Council duties are defined in Paragraph 8, Section 3, of the Bylaws. The Judicial Council investigates Association activities which pertain to medical ethics, dissention and disputes, complaints by patients against members of the Association, and questions of membership and disciplinary action. The Council reviews and recommends charters for county medical societies. The Council also is the interpretive body for the Association Bylaws. A component county medical society is the basic unit for discipline of its members. Any member subject to such action has a right of appeal to the Judicial Council. The Council may be required to review component county medical societies in respect to their adherence to binding policies adopted by the House of Delegates of the Association.

Since the last Annual Meeting of the Association, the Council has convened on the following occasions: May 1, 1985; September 7, 1985; January 4, 1986; and April 4, 1986. The current membership of the Council is as follows: Joseph H. Davis, M.D., Chairman, Miami; O. Frank Agee, M.D., Gainesville; Robert J. Brennan, M.D., Ft. Lauderdale; Maurice H. Laszlo, M.D., North Miami Beach; and Kenneth C. Kiehl, M.D., Sarasota. The Council has been staffed by Donald W. Weidner, Esq., FMA Associate General Counsel.

The Council's activities are summarized under the following headings:

Ad Hoc Committee

The procedures for handling patient and member grievances were originally considered by the House of Delegates in 1972. Because of the length of time since that consideration, the Council recommended in 1985 to the Board of Governors, and the Board adopted a motion that the procedures be resubmitted to the 1985 House of Delegates for reaffirmation.

At the time the current procedures were reaffirmed, it was recognized that changes were essential since, as a result of the malpractice insurance crisis, a legislative and news media spotlight had focused upon the way organized medicine fulfills its responsibilities in handling grievances.

The Judicial Council recommended that President Dr. Perez be authorized to appoint an ad hoc committee of the Judicial Council to recommend changes to the grievance procedures of the Association. The Board approved this recommendation and Dr. Perez appointed Richard S. Hodes, M.D., Robert N. Webster, M.D. and the members of the Judicial Council to serve on the ad hoc committee. Dr. Perez also authorized the retention of the Honorable Fred Karl, Esq., as a special consultant.

The ad hoc committee has met on three occasions and spent many hours studying this issue in-depth. The committee has now prepared its final report and recommendations which are being submitted to the Board of Governors for consideration at the June 1986 meeting. The report recommends important changes which will make the handling of grievance cases more fair and uniform.

Grievances

Within the past year, we have seen a continued increase in the number of grievances referred to the Council. At the time of the Annual Meeting last year, we had thirty-five open cases. Today we have forty-two open cases and have closed out another seventy-seven cases. Additionally, we received a significant number of cases that were not within the jurisdiction of the Council, either because the physician involved was not an FMA member or because the person complained about was not a doctor of medicine.

Review of County Medical Society Revisions to Charter and Bylaws

During the past year, the Council continued to review bylaws amendments of county medical societies to assure that such amendments are not in conflict with the Bylaws of the Florida Medical Association. County medical societies are urged to submit proposed changes in charters and bylaws to the Judicial Council in a timely manner for such review.

As part of its review responsibility, the Council was asked by the Brevard County Medical Society to determine whether county medical societies could have more stringent standards for

membership than those imposed by FMA. The Council was of the opinion that component societies could have more stringent standards. This issue went to the Board of Governors which referred it back to the Council for further study. After further review, the Council remains of the opinion that the county societies can have more stringent membership standards. If it is believed that county societies should have identical membership requirements, then an amendment to the FMA Bylaws imposing such a requirement would have to be adopted.

Sunset of the Medical Practice Act

The Judicial Council made an in-depth review of the medical practice act which was scheduled for sunset in 1986. The Council forwarded recommendations for change to the Chairman of the Council on Legislation.

Florida Medical Association
Policy Statement RE: Advertising (1979)

During the past year, the Council continued to review request for changes to the endorsed specialty listing section of the Florida Medical Association Policy Statement.

Members desirous of a new telephone listing should review the approved specialty code listing found within the American Medical Association Directory of Physicians. The Council considers the following as guidelines when reviewing such requests:

a) the listing serves a public need;
b) it is not redundant with another listing;
c) it is a genuine aspect of the practice of medicine;
d) it has board certified recognition;
e) it describes what the physicians does.

The following is the current listing of endorsed specialty headings for yellow page advertising:

FMA ENDORSED SPECIALTY LISTINGS
FOR USE IN YELLOW PAGE ADVERTISING

1. Aerospace Medicine
2. Allergy & Immunology
3. Allergy & Immunology-Pediatric
4. Anatomic Clinical Pathology
5. Anatomic Pathology
6. Anesthesiology
7. Blood Banking
8. Cardiovascular Disease
9. Child Neurology
10. Child Psychiatry
11. Clinical Pathology
12. Chemical Pathology
13. Colon & Rectal
14. Colon & Rectal Surgery
15. Dermatology
16. Dermatopathology
17. Diagnostic Radiological Physics
18. Diagnostic Radiology
19. Emergency Medicine
20. Endocrinology & Metabolism
21. Family Practice
22. Forensic Pathology
23. Gastroenterology
24. General Practice
25. General Preventive Medicine
26. Genetic Medicine
27. Gynecologic Oncology
28. Hand Surgery
29. Hematology
30. Hypnosis
31. Infectious Disease
32. Internal Medicine
33. Maternal & Fetal Medicine
34. Medical Microbiology
35. Medical Nuclear Physics
36. Medical Oncology
37. Neonatal-Perinatal Medicine
38. Nephrology
39. Neurological Surgery
40. Neurology
41. Neuropathology
42. Nuclear Medicine
43. Nuclear Radiology
44. Obstetrics & Gynecology
45. Occupational Medicine
46. Ophthalmology
47. Ophthalmology — Pediatric
48. Oral & Maxillofacial Surgery
49. Orthopedic Surgery
50. Otolaryngology — Head & Neck Surgery
51. Pathology
52. Pediatric Cardiology
53. Pediatric Endocrinology
54. Pediatric Hematology — Oncology
55. Pediatric Nephrology
56. Pediatric Surgery
57. Pediatrics
58. Physical Medicine & Rehabilitation
59. Plastic Surgery
60. Proctology
61. Psychiatry
62. Psychiatry & Neurology
63. Public Health
64. Pulmonary Disease
65. Radiologic Physics
66. Radioisotopic Pathology
67. Radiology
68. Reproductive Endocrinology
69. Rheumatology
70. Surgery
71. Therapeutic Radiological Physics
72. Therapeutic Radiology
73. Thoracic Surgery
74. Urology
75. Vascular Surgery

Committee on Impaired Physicians

The Reference Committee commended Dr. Guy T. Selander, Chairman, and Dr. Roger A. Goetz, Medical Director of the Impaired Physicians Program, for their dedication and many hours of hard work on this important Committee.

The Report of the Committee on Impaired Physicians was adopted as presented.

Committee on Impaired Physicians
Guy T. Selander, M.D., Chairman

With the help of fulltime medical direction, the Committee on Impaired Physicians has completed one of its most successful years since it was organized in 1980. Since the retention of Roger A. Goetz, M.D., as fulltime Medical Director in February of 1985, intake into the program has increased dramatically and relationships with other health professions have been established or strengthened and improved.

The Committee has met three times since the last Annual Meeting: on August 9, 1985, in Jacksonville; September 27, 1985, at Kissimmee; and March 21, 1986, at Hollywood. A summary of some of the major projects and activities of the Committee appears below:

Caseload: From January 1, 1985, to June 1, 1986, 180 new cases entered the program, exceeding by four the number for the entire four-year period beginning January 1981 ending December 1984. Following is a statistical summary of cases entering the program January 1, 1985, to June 1, 1986:

Cases Under Development		34
Program Participants Hospitalized (Evaluation and/or Treatment on date of report)		12
Inappropriate for Program		15
Discharged or Refused Program Reported to DPR Investigator		11
Completed 28 Day Program Refused Extended Care		4
Successfully Completed Treatment and In Aftercare		71
Enrolled in Program in Recovery		3
Treated Outside of State Reported to Program in Aftercare		2
Treated and Not Reported to Program but Subsequently Requiring Services of Program		14
Re-enrolled in Program after Coercive Reporting		3
Deaths/Suicide		6
Psychiatric Protocol (Sexual)		2
Psychiatric Protocol (Other)		3
TOTAL (Since January, 1985)	180	180
TOTAL Cases enrolled from 1981-1984		176
TOTAL Other Health Care Providers enrolled in Program (Dentists, Pharmacists, Nurses, etc.)		15
TOTAL Number of Cases as of June 1, 1986		371

Activities of Medical Director: During the period April 1, 1985, to June 1, 1986, the Medical Director was involved in a total of 334 interventions, media interviews, meetings as a speaker and other activities. The breakdown is as follows:

Conference (as program participant): interdisciplinary/advocacy, 26; and medical (regional or national), 13.

Presentation of Programs: medical (educational), 36; general public, 23; other health care providers, 21; State Legislature, 18; and recovering community, 18.

Presentation of Programs (media appearances exclusive of telephone or news interview): 17.

Consultations for Development of Concurrent Professional Impairment Programs: 14.

Onsite Activities Involving Treatment Providers: 24

Onsite Individual Interventions/Monitoring Activities: 124

Intervention Workshops: The Committee conducted two more highly successful Workshops on Intervention with Impaired Physicians, the sixth and seventh in the series. One session, at Kissimmee on September 28-29, 1985, attracted 48 participants and included a presentation by David Canavan, M.D., Medical Director of the Impaired Physicians Program of the Medical Society of New Jersey. Seventy-four physicians and others attended a March 22-23 workshop at Hollywood, which was addressed by Barton A. Harris, M.D., Medical Director of the New York Impaired Physicians Program.

Section on Chemical Dependency: The Committee continues to be involved in continuing medical education through its sponsorship of the Section on Chemical Dependency at FMA Annual Meetings. Former Clearwater pediatrician Donald I. Macdonald, M.D., who has served for the past two years as Administrator of the federal Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), will be featured on this year's program which is scheduled for Wednesday afternoon, September 17.

Survey Manual and Questionnaire: The Committee has finally completed and published its survey manual and questionnaire for treatment providers. These documents will assist greatly in the objective evaluation of treatment facilities that wish to receive patients through the FMA Impaired Physicians Program.

Board of Medical Examiners: Negotiations between the Department of Professional Regulations and the Board of Medical Examiners on one hand and the FMA on the other aimed at a partial merger of private and public sector impaired physicians programs broke down completely early in 1986. A key element of the plan would be the appointment of the IPP's Medical Director to serve also as the Department of Professional Regulation's Impaired Professional Consultant, thereby strengthening both plans. Just as it appeared that an agreement was in the offing, negotiations broke down completely when DPR demanded that the IPP Medical Director sever his relationship with FMA before contracting with DPR.

Prescription Drug Curriculum: At the request of the FMA Committee on Substance Abuse, the Committee on Impaired Physicians reviewed a special CME curriculum developed by the Substance Abuse group, made suggestions for improvement and ultimately endorsed it. The curriculum is entitled "Protecting Your Medical Practice: Clinical, Legal and Ethical Issues in Prescribing Abusable Drugs." The program is designed for physicians who are in need of some refresher training in the proper prescription of controlled substances.

Non-Addictive Impairments: The Medical Director has been receiving an increasing number of cases in which the primary problem seems to be not addiction but other impairments such as senility, psychiatric illness and aberrant sexual behavior. Policy adopted by the House of Delegates limits our program to addictive diseases. The Committee believes that to expand the scope of the program would dilute the present activity with regard to addictive diseases. Nevertheless, other causes of impairment cannot be ignored. The Committee has recommended to the Board of Governors that for a trial period of six months, the Committee be permitted to offer screening, evaluation and referral — but not monitoring — of such cases. Meanwhile, protocols governing such cases would be developed in cooperation with the impaired physicians programs of New York and New Jersey.

Local Impaired Physicians Committees: Networking is important to an activity like the Impaired Physicians Program. Therefore, the medical society be encouraged to appoint an impaired physicians committee. Seventeen of FMA's 47 county medical societies have established such committees.

Florida Medical Political Action Committee

The Reference Committee appreciated the work and efforts of the FLAMPAC Committee chaired by Dr. James G. White.

The Reference Committee recommended that the report of the Florida Medical Political Action Committee be adopted and that the leadership of component county medical societies present at the

meeting of the House of Delegates be requested to make every effort at the local level to increase membership in local, state and national PAC organizations including physician, financial and individual participation in the campaigns of political candidates of their choice. The Report of the Florida Medical Political Action Committee was adopted as presented.

Florida Medical Political Action Committee
James G. White, M.D., President

Political Action Program — 1985

FLAMPAC spent the year of 1985 in developing plans for active involvement in Congressional and Florida Legislative campaigns. Particular emphasis has been placed upon identification of the local financial and volunteer resources that can be generated for "Target Races." Additional staff capability has been added in order to complete this program and to also give greater support to local volunteer activities.

The Board, in cooperation with local physicians and their spouses, is completing the selection of FLAMPAC candidates and the determination of those races that warrant maximum attention (Target Races). Since most Congressional incumbents appear secure, a majority of FLAMPAC's efforts will be directed toward building a greater base of support for tort and medical malpractice reforms in the 1987-88 Sessions of the Florida Legislature.

There is expected to be a fairly significant turnover in the Florida Legislature due to the large number of incumbents either not running for reelection or running for higher office. In addition, turnovers are expected to occur because of vulnerability of several incumbents.

Membership

Final FLAMPAC membership contributions in 1985 exceeded the quota established by more than $46,000. This occurred in spite of a lower than projected membership total. A significant achievement is the record number of 4,483 individuals who joined FLAMPAC as Sustaining Members. This increased financial support by physicians and their spouses will enable FLAMPAC to play a significant financial role in Congressional and Legislative races.

FLAMPAC received two awards from AMPAC for membership achievements in 1985. These were:

Second Place in Total Contributions Category
Second Place in Membership to Potential Category

FLAMPAC Officers and Board

The FLAMPAC Board of Directors elected the following persons as officers for FLAMPAC during 1986:

Robert E. Windom, M.D., President
James G. White, M.D., Vice President
Carlos G. Llanes, M.D., Secretary
Louis C. Murray, M.D., Treasurer
Donald C. Jones, Assistant Treasurer

Note: Due to the resignation of Robert E. Windom, M.D., James G. White, M.D. is FLAMPAC President. The position of Vice President is vacant until the 1987 Annual Meeting of FLAMPAC.

The FMA Board of Governors, as provided in the FLAMPAC By-Laws, has appointed an outstanding list of physicians and their spouses to serve as the FLAMPAC Board of Directors during 1986. Persons appointed to the FLAMPAC Board of Directors for 1986 are:

Florida Congressional Districts

(1st) William W. Thompson, M.D.
(2nd) Terence P. McCoy, M.D.
(3rd) Mrs. James H. Corwin
(4th) James G. White, M.D.
(5th) Louis C. Murray, M.D.
(6th) Frank R. Wilkerson Jr., M.D.
(7th) Frank C. Coleman, M.D.
(8th) James L. West, M.D.
(9th) Donald G. Nikolaus, M.D.
(10th) John W. Glotfelty, M.D.
(11th) Brian P. Gibbons, M.D.
(12th) Donald L. Ames, M.D.
(13th) Robert E. Windom, M.D. (Resigned)
(14th) Dick L. Van Eldik, M.D.
(15th) T. W. Hahn, M.D.
(16th) Stanley I. Margulies, M.D.
(17th) James W. Bridges, M.D.
(18th) Margaret Skinner, M.D. (Resigned)
(19th) Warren Lindau, M.D.

Members of FMA Auxiliary

Mrs. B. David Epstein
Mrs. Arthur L. Eberly
Mrs. Donald G. Nikolaus

Liaison Representatives from FMA Board of Governors

Luis M. Perez, M.D.
Kay K. Hanley, M.D.

Members of FMA Council on Legislation

Thomas M. Daniel, M.D.
Michael J. Pickering, M.D.

Members from the State At-Large

H. Quillian Jones Jr., M.D.
R. Benjamin Moore, M.D.
Carlos G. Llanes, M.D.
Juan Wester, M.D.
Alvin E. Smith, M.D.
Richard S. Hodes, M.D.

President-Elect of FMA Auxiliary

Mrs. V. A. Marks (Ex-officio)

(Replacements for Board vacancies are currently being processed for FMA Board of Governors appointment.)



Dr. Luis M. Perez shows off his new Presidential Medallion to Dr. Maria P. Perez.

FLAMPAC President Appointed to Federal Office

Robert E. Windom, M.D. was appointed by President Reagan to serve as Assistant Secretary of Health and Human Services. The Florida Medical Political Action Committee is extremely proud of this recognition of the outstanding record and capability for leadership that Dr. Windom has demonstrated. The nation will be the richer for the stewardship of Robert E. Windom, M.D.

Florida Physician's Association

The Reference Committee was encouraged by current activities and proposals to begin a contract negotiation service.

The Report of the Florida Physicians Association was adopted as presented.

Florida Physicians Association
Charles J. Kahn, M.D., President

The FPA began its year by investigating the feasibility of becoming a recognized bargaining agent for the Association's members in discussions with HMOs, IPAs, insurance carriers, etc.

Extensive legal research was conducted on behalf of FPA by William Adams, Esquire, as well as by Donald Weidner, Esquire. As a result of that research, FPA undertook, in cooperation with FMA, an educational campaign aimed at educating physicians regarding the unionization issues.

The FPA co-sponsored a workshop on physician unionization and collective bargaining at the FMA Leadership Conference. The FPA also prepared in cooperation with FMA the "Florida Physicians Guide to Contracting" which was mailed to all FPA/FMA members.

Finally, the FPA Executive Committee adopted in principal a proposal that FPA begin a contract negotiation service through which FPA would, on behalf of individual members, utilize trained negotiators to represent the members in contract negotiations with HMOs, IPAs, hospitals, etc. It is anticipated that the program will be submitted for final approval at the FPA Annual Meeting in September.

Florida Medical Association Auxiliary

The Reference Committee commended the FMA Auxiliary and their President, Mrs. Milton (Jo) Tignor, for its outstanding contributions during the year.

The Report of the Florida Medical Association Auxiliary was adopted as presented.

Florida Medical Association Auxiliary
Mrs. Milton (Jo) Tignor Jr., President

The Florida Medical Association Auxiliary is most proud of its accomplishments during 1985-86. Although we experienced a decline in membership on the State and National levels, our goals, programs and projects remain strong and more viable than ever.

1. **Fund Raising Activities** — The Auxiliary has been extremely active in fund raising activities. A total of $101, 415.92 was raised for the American Medical Association Education Research Foundation. Contributions totaling approximately $8000 will be presented to Interplast South. Thousands of dollars have been raised by Auxilians across Florida to assist young people in our state with their goals of careers in health related fields.

2. **Child Abuse** — Our major health project for the year was emphasized with programs, projects and fund raisers by over 20 county auxiliaries. Dade County raised $22,000. Lee County was instrumental in getting a Personal Safety Curriculum instituted in the Lee County School System beginning in 1986-87.

3. **Missing Children Poster Program** — The Missing Children Program drew twelve television and radio stations to a press conference in Tampa. Over 25 additional requests have been received from other media representatives.

4. **Ad Hoc Committee** — An Ad Hoc Committee has been formed to study the goals and objectives of the Auxiliary. It will develop an "Action Plan" for the Auxiliary. This plan will help us reassess our goals, programs, projects and meeting structure.

5. **Miscellaneous Meetings** — Successful District Meetings were held in the Spring. A Spring Leadership Conference was held in late April in Orlando. Mrs. Edward J. (Jean) Hill, AMA Auxiliary Southern Regional Vice President, conducted an orientation workshop for incoming county officers. Mr. Dave Partridge, Director of Public Relations for the Greenville Hospital System in Greenville, South Carolina, presented a very informative Seminar on Media Communications and Parlimentary Procedure. Mrs. R. Benjamin Moore (Connie), Past President of the Florida Medical Association Auxiliary, spoke on how "Families Hurt Too in Medical Malpractice Cases."

6. **Legislative Activities** — The Auxiliary's Annual "Days at the Capital," held in mid-May for the first time instead of the opening week of the session, drew record numbers. An entire day was set aside for lobbying efforts and the opportunity to attend sessions of the House and Senate, as well as witnessing timely Committee hearings on tort reform. Once again, all legislators were invited to the Governor's Club reception. The Legislative Seminars that were held earlier in the year in the largest ten counties in the state helped to stimulate legislative interests. The Auxiliary is also proud that so many Auxilians participated in the "Day in the Right Directions" Assembly in Tallahassee.

7. **AMA-A Annual Convention** — Seventeen delegates attended the AMA Auxiliary Annual Convention in Chicago. The Auxiliary received an award for the formation of the new Okaloosa County Medical Society Auxiliary and a Recognition Award from AMA/ERF for having the third largest total contributions in the nation.

8. **FMA-A Annual Meeting** — Plans are being finalized for the Annual Meeting in September. The first House of Delegates will convene on Wednesday, September 17, at 1:30 p.m. The second House will begin Thursday, September 18, at 8:30 a.m. Our very special guests will be Mrs. Mylie (Pat) Durham, President of the American Medical Association Auxiliary, and Mrs. Frank (Margaret) Morgan, President of the Southern Medical Association Auxiliary. You are all invited to attend a reception given by the Palm Beach County Medical Society honoring Mrs. Milton R. Tignor, President, and Mrs. V.A. Marks, President-Elect, aboard the "Spirit" cruise ship. During the reception we will cruise along the Intracoastal Waterway while enjoying dinner and live entertainment aboard "The Spirit."

The Florida Medical Association is very special to me, as well as to each Auxilian across our great state. On behalf of the entire Auxiliary, I would like to express my gratitude for the support the Auxiliary has received from the Florida Medical Association Board of Governors during the past year, as well as my personal thanks for the warmth and friendliness with which that support was given.

Report C of the Board of Governors

The Reference Committee considered the Report C of the Board of Governors and commended the Board for its outstanding performance during the past year.

The Committee commended Dr. Yank D. Coble Jr., FMA Treasurer, for his articulate and comprehensive report on the Association's finances.

The following actions of the nominations and recommendations were suggested by the Reference Committee:

The nomination of James F. Richards Jr., M.D., for Certificate of Merit of the Florida Medical Association was adopted.

The nomination of Hector R. Mendez, M.D., and Bernard Seindenberg, M.D., F.A.C.P.S., to receive the Certificate of Appreciation of the Florida Medical Association was adopted.

The Speaker presented the Certificate of Merit and the Certificate of Appreciation as commendations for exceptional and outstanding service to the Association, to the medical profession, and to the public in accordance with the Principles of Medical Ethics. This year's recipient of the Certificate of Merit, Dr. James F. Richards Jr., was escorted to the podium by Dr. Joseph H. Matthews and Dr. Cecil B. Wilson to receive his award.

Certificate of Merit
James F. Richards Jr., M.D.

Whereas, James F. Richards Jr., M.D., of Orlando, Florida, has rendered exceptional service to the Florida Medical Association, to organized medicine and to the public; and

Whereas, This dedicated physician attended the University of North Carolina where he received his medical degree and completed post-graduate work at the University of California at Los Angeles; and

Whereas, Dr. Richards completed an internship at Georgia Baptist Hospital and two residencies, one in general surgery and one in orthopedic surgery; and

Whereas, He has held memberships on seven hospital staffs including Orlando Regional Medical Center and Orange Memorial Hospital; and

Whereas, This active physician is a member of numerous medical societies including the American Medical Association, Florida Medical Association in which he has served on numerous committees, Florida Orthopedic Society, Southern Medical Association, Irish American Orthopedic Society and Orange County Medical Society in which he has served in numerous capacities and as President; and

Whereas, Dr. Richards has served on the Board of Trustees of the John Young Museum and Planetarium, on the Board of Directors of the Central Florida Chapter March of Dimes and on the Central Florida Safety Council Board; and

Whereas, He has authored 15 publications and articles; and

Whereas, Dr. Richards has given freely of his time and talents to the medical community and to the people of the State of Florida; therefore be it



James F. Richards Jr., M.D. of Orlando, accepts his Certificate of Merit from FMA President Dr. Luis M. Perez.

RESOLVED, That a Certificate of Merit be presented to James F. Richards Jr., M.D., as a token of the warm regard and respect that the Association holds for the many years of outstanding service rendered by this exceptional physician.

Dr. Selander then announced the recipients of the Certificate of Appreciation. Dr. Selander asked Dr. H.S. Budd Treloar and Dr. H. Frank Farmer to escort Dr. Bernard Seidenberg to the podium to receive his award.



FMA President Dr. Luis M. Perez presents a Certificate of Appreciation to Bernard Seidenberg, M.D., F.A.C.S., Daytona Beach.

Certificate of Appreciation
Bernard Seidenberg, M.D., F.A.C.S.

Whereas, Bernard Seidenberg, M.D., of Daytona Beach, Florida, tirelessly and ably has served the medical profession and the State of Florida for more than 15 years; and

Whereas, Dr. Seidenberg was born in Jersey City, New Jersey, September 5, 1922, attended undergraduate and medical school at New York University and received his medical degree in 1947; and

Whereas, This honorable individual served in the United States Army, from 1943 until 1946, and the United States Air Force, where he served as Assistant Chief and Chief of Surgery from 1952 until 1954 in Anchorage, Alaska; and

Whereas, This dedicated general surgeon completed his internship at Queens General Hospital in New York and completed an Assistant Surgery Residency at Montefiore Hospital in New York City and has had 15 teaching and hospital appointments; and

Whereas, Dr. Seidenburg is Volusia County Medical Society's Program Director and Chairman of the Public and Professional Relations Committee; and

Whereas, This able physician has served the Florida Medical Association and American Medical Association; and

Whereas, He is or has been a member of Collegium Internationale Circurgiae Digestivae, Society for Surgery of the Alimentary Tract and International Cardiovascular Society; and

Whereas, Dr. Seidenberg has participated in six research activities and written 49 publications; and

Whereas, This active physician has been the coordinator of the Volusia County Medical Society's Mini-Intership Program for the past two years; and

Whereas, Dr. Seidenberg has continually given of his time and talents for the enhancement of quality health care for all citizens; therefore be it

RESOLVED, That a Certificate of Appreciation be presented by the Florida Medical Association to Bernard Seidenberg, M.D., as a token of the warm appreciation that the Association holds for this fine gentleman and his exemplary record of service to mankind and to his profession.



FMA President Dr. Luis M. Perez presenting the Certificate of Appreciation to Hector R. Mendez, M.D., Orlando.

Dr. Selander then asked Dr. Manuel J. Coto and Dr. Richard J. Bagby to escort Dr. Hector R. Mendez to the podium to receive his Certificate of Appreciation Award.

Certificate of Appreciation
Hector R. Mendez, M.D.

Whereas, Hector R. Mendez, M.D., of Orlando, Florida, tirelessly and ably has served the medical profession and the Florida Medical Association since 1962; and

Whereas, Dr. Mendez was born in Matanzas, Cuba, October 21, 1923, attended the University of Havana where he received his medical degree in 1952; and

Whereas, This able physician completed an internship and residency at St. Vincent's Hospital in Jacksonville; and

Whereas, This active physician has served the Florida Medical Association's House of Delegates, Impaired Physicians Committee, as a FLAMPAC Representative, School Advisory Board and the Reference Committee; and

Whereas, Dr. Mendez has served on the Orange County Medical Society's Executive Committee, Board of Censors, ORANGEPAC, and as President; and

Whereas, He is a member of the Cuban Doctors Association and Hospice Advisory Medical Board; and

Whereas, Dr. Mendez has instructed high school students on health care and medicine as a profession, organized a series of local radio programs on health care and has been highly active during the Mariel boatlift, organizing Cuban doctors to assist refugees with health problems and in finding homes and employment; and

Whereas, Dr. Mendez has continually given of his time and talents for the enhancement of quality health care for all citizens; therefore be it

RESOLVED, That a Certificate of Appreciation be presented by the Florida Medical Association to Hector R. Mendez, M.D., as a token of the warm appreciation that the Association holds for this fine gentleman and his exemplary record of service to mankind and to his profession.

Dr. Selander announced the Harold S. Strasser, M.D., Good Samaritan Award recipients, Dr. Ivette C. Valladares and Dr. Victor Hochman. Neither were present, so the awards were accepted by Dr. Richard J. Bagby, President of the Orange County Medical Society.

Harold S. Strasser, M.D.
Good Samaritan Award
Ivette C. Valladares, M.D.

Whereas, Ivette C. Valladares, M.D., of Orlando, Florida, with no expectation of compensation, and in spite of any danger to herself, travelled with Victor Hochman, M.D., to Mexico in September of 1985 to assist with the earthquake victims, taking with them food, clothing and medical supplies and equipment donated by the people of Orlando to distribute; and

Whereas, In December of 1985, she returned to Mexico on a follow-up visit to perform surgery with the supplies they had provided earlier; and

Whereas, This physician humanitarian travelled with Dr. Hochman to Columbia, South America, in November of 1985 to assist with the earthquake victims in that country as well, taking medical supplies with them; and

Whereas, Dr. Valladares returned to Columbia in May with two ambulances which were donated; and

Whereas, She graduated from Liberty High School in Youngstown, Ohio, in 1973; attended Instituo de Verdaguer and Universidad Central de Barcelona Medical School, both in Barcelona, Spain; and graduated from the Universidad Central de Este in the Dominican Republic where she received her medical degree in May, 1980; and

Whereas, This generous lady had experience from Riverside Hospital in Toledo, Ohio, and St. Elizabeth Hospital in Youngstown, Ohio; and

Whereas, Dr. Valladares presented her dissertation paper titled "Incidence and Causes of Cardiac Failure and Pulmonary Edema in Ten Patients on Peritoneal Dialysis," and

Whereas, This active physician currently serves on a two-year term Steering Committee of the United Nations Association of the United States of America; is President of the Ibero-American Coalition of Florida; is on the Board of Directors of the Catholic Diocese Newman House, and writes a medical column in a local newspaper; and

Whereas, She was a member of the Future Physician's Club and Speechmaster Speech Club in high school and was president of her graduating class in medical school; and

Whereas, This unselfish lady has participated in the Pan American Junior Athletics Championship Games on the International Relations/Protocol Committee and was a charter member of the Planning Committee for the College of Health Center for Latin American Health Affairs; therefore be it

RESOLVED, That upon unanimous vote of the Board of Governors, the Florida Medical Association at its 112th Annual Meeting in Hollywood, Florida, September 17-21, 1986, present to Ivette Valladares, M.D., the Harold S. Strasser, M.D., Good Samaritan Award with sincere appreciation for her humanitarian acts on behalf of her fellow man.

Harold S. Strasser, M.D. Good Samaritan Award
Victor Hochman, M.D.

Whereas, Victor Hochman, M.D., of Winter Springs, Florida, with no expectation of compensation, and in spite of any danger to himself, travelled to Mexico in September 1985 to assist Ivette Valladares, M.D., with the earthquake victims, taking with them food and clothing donated by the people of Orlando; and

Whereas, This physician humanitarian also took and distributed medical supplies and equipment; and

Whereas, Dr. Hochman again travelled with Dr. Valladares in November 1985 to Columbia, South America, to assist with earthquake victims in that country and took medical supplies to distribute; and



Dr. Richard Bagby, Winter Park, President of Orange County Medical Society accepts Good Samaritan Awards from FMA President Luis M. Perez, M.D., for Ivette C. Valladares, M.D., Orlando, and Victor Hochman, M.D., Winter Springs; neither of the two recipients were able to attend.



FMA Immediate Past President Frank C. Coleman, M.D., presents a Certificate of Grateful Recognition to John Richardson, former Hillsborough County Executive Vice President, Tampa.

Whereas, He is a native of Buenos Aires, Argentina, attended the University of Buenos Aires from which he received his medical degree; and

Whereas, Dr. Hochman completed post-graduate training at Beth Israel Medical Center in New York City and Massachusetts Medical Center in Springfield; and

Whereas, This generous gentleman is Board eligible in pediatrics; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors, the Florida Medical Association at its 112th Annual Meeting in Hollywood, Florida, September 17-21, 1986 present to Victor Hochman, M.D., the Harold S. Strasser, M.D., Good Samaritan Award with sincere appreciation for his humanitarian acts on behalf of his fellow man.

Dr. Selander called Dr. Frank C. Coleman who recognized John Richardson with a Certificate of Grateful Recognition. Mr. Richardson was escorted to the podium by Dr. Ralph E. Rydell and Dr. Miguel R. Alonso.

Recommendation No. C-1 was not acted on in view of the fact that it had been previously acted upon at the First House of Delegates.

Recommendation No. C-2 was adopted as presented.

Recommendation No. C-3 was adopted as presented.

Recommendation No. C-4 was adopted as presented.

Recommendation No. C-5 was adopted as corrected with the spelling of "principle."

Recommendation No. C-6 was adopted as presented.

Recommendation No. C-7 was adopted as presented.

Recommendation No. C-8 was adopted as presented.

Recommendation No. C-9 was adopted as presented. Recommendation No. C-9 proposed the following Bylaws amendments:

Chapter 8 — Councils and Sections — Provides for the establishment of a resident section and student medical section with one vote each in the House of Delegates.

Chapter 4 — House of Delegates — Provides for the recognition of new delegates in the House of Delegates; reporting of credentials and alternate delegates.

Chapter 8 — Councils — Provides for authorization of the Council on Hospital Medical Staffs to select its delegate to the House of Delegates from the Council membership.

Chapter 8 — Councils — Provides for the creation of the Council on County Medical Society Officers.

Chapter 4 — House of Delegates — Provides for elimination of the 250 cap on the number of delegates in the House of Delegates and establishes a ratio of one delegate for every 40 active members of the FMA within each county medical society.

Chapter 9 — Committees — provides for the designation of the Committee on Membership Development as a standing committee.

Chapter 10 — Income and Expenditures, Section 2, Items 2 and 5 — Provides for an increase in the entrance fee for FMA membership and for modification of the delinquent and drop dates for non-payment of FMA dues.

Chapter 1 — Membership — Provides for the elimination of the specific prohibition in the Bylaws that exempts life members from all dues and assessments.

Report C
of
Board of Governors

Luis M. Perez, M.D., Chairman

On behalf of the Board of Governors, your Chairman is highly pleased to submit this report to the House of Delegates regarding the many positive and far reaching activities that have been undertaken by your Board and the Association's Councils and Committees during the past year.

It has been a year of great challenge and many successes as we have diligently worked to continue to build on the foundations for a new direction for our organization begun under the capable leadership of my predecessor, Dr. Frank Coleman.

Our efforts throughout the year have been focused on the future of our profession and our clarion call has been unity as the key to our success.

When I assumed office as your President in May 1985, I issued to each of you a call for unity and working together for a new beginning and direction for the Florida Medical Association on behalf of the physicians of Florida and their patients. During the past year, we have worked hard to achieve that goal; and I feel that we have had many successes. Our greatest achievement was the Assembly for Liability Reform held in Tallahasse on Monday, April 21. Never before have physicians come together in such a single voice and unified effort to achieve a common goal. This unity was shared with representatives from 76 other organizations representing hundreds of thousands of Floridians who are being affected by the liability crisis in our state.

Moreover, it is my sincerest hope that this same spirit of unity and cooperation will carry forward into the future as we continue to address the many other crucial problems facing medicine in our state. We have truly taken a step in the right direction in resolving the professional liability crisis, and we have truly established a new beginning and a new direction for the Florida Medical Association.

As you study and deliberate the reports in the delegates handbook including the Association's programs and priorities, I hope that you will agree that we are effectively working to address these issues of concern to the membership as well as the citizens of Florida.

Your Chairman has been honored for having had the opportunity of working with the many dedicated physicians who have actively served during the past year on the Association's Councils and Committees. They have given freely of their time and talents and spent hundreds of hours working in all our behalf for the betterment of health. I would also like to extend special thanks to the FMA Auxiliary for their continuing exemplary efforts and to all our county medical societies for the outstanding cooperation and assistance they have provided the FMA throughout the year.

There is no adequate way to express my heartfelt affection and appreciation to those dedicated physicians with whom it has been my personal privilege and honor to serve on the Board of Governors. Each of your Board members have given generously of their time and talents and have kept the best interest of all physicians and the betterment of health care uppermost in their minds during this difficult year and have acted thoughtfully and wisely on your behalf.

James B. Perry, M.D., President-Elect
James G. White, M.D., Vice President
Henry M. Yonge, M.D., Secretary
Yank D. Coble Jr., M.D., Treasurer
Frank C. Coleman, M.D., Immediate Past President — 1987
J. Lee Dockery, M.D., Past President — 1986
Guy T. Selander, M.D., Speaker of House
Charles B. McIntosh, M.D., At Large — 1986
Gerold L. Schiebler, M.D., District A — 1986
Kay K. Hanley, M.D., District B — 1987
A. Frederick Schild, M.D., District D — 1988
Dick L. Van Eldik, M.D., District C — 1989
Eugene G. Peek Jr., M.D., HRS — 1986
Charles K. Donegan, M.D., AMA DEL — 1986
Robert N. Webster, M.D., SBME —1986
Jane Ailene Daniel, Student Member — 1987

To my successor, Dr. James Perry, I extend my best wishes and my optimistic belief that his year as President will be a deeply rewarding experience, as mine has been. With the level of leadership in Florida medicine and the many dedicated physicians who give of their time and talents in behalf of their colleagues, he can only succeed.

Major Activities

1986 Annual Meeting: The Board established the format for the 1986 FMA Annual Meeting at the Diplomat Hotel, Hollywood, Florida, September 17-21, 1986, and approved the scientific programs which will allow physicians to earn up to 20 hours in CME credit. (See also Board Report A re: FMA Annual Meeting.)

1986 FMA Leadership Conference: The 1986 Leadership Conference of the Florida Medical Association (FMA) was held in conjunction with the Interim meeting of the House of Delegates January 24-26 at the Lincoln Hotel at Urban Centre, Tampa. The theme of the highly successful meeting was "Focus on the Future," embracing the concept of the FMA as a united team working to meet the future exigencies confronting the medical profession and the health care needs of society. Attendees had a broad range of timely topics to choose from in the multiple workshops that were held including: Legislative Issues, Unionization, Contracts/Joint Ventures, Media Relations, Continuing Medical Education, Hospital Medical Staff Issues, Missing Children, Leadership Skills.

Activities on the first day of the Conference included the Second Annual Leadership Skills Seminar for Women Physicians, the Statewide Council on Hospital Medical Staffs meeting, a Workshop for Continuing Medical Education Sponsors, Workshop on Media Relations, and a Seminar on Missing Children. Activities on the second day consisted of the First House of Delegates interim meeting and Workshops on Unionization, Legislation, and Contracts. Senator Ken Jenne, D-Hollywood, was the featured luncheon speaker. Other distinguished legislators and federal and state officials, including Florida Supreme Court Justice Rosemary Barkett, participated in

the Conference. The third day of the Conference consisted of the Second House of Delegates interim meeting. Action by the House of Delegates focused on approving the FMA's 1986 legislative program as recommended by the Board of Governors and resolutions from county medical societies. Luis M. Perez, M.D., President of the FMA, addressed the House of Delegates informing them that physicians faced an uphill battle in seeking relief from the malpractice crisis. The FMA's success in the 1986 legislative session relating to professional liability, tort reform, the reorganization of the Department of Health and Rehabilitative Services, and other legislative issues were directly attributable to the positive and timely action taken by the House of Delegates at the Leadership Conference.

FMA Priorities 1985-86: The Board approved the following Association priorities for 1985-86. The status of the Association's activities in implementing the priorities is reflected throughout the delegates handbook. Additional information will be included as an appendix to Report C of the Board in the delegates packet.

1. The Florida Medical Association will continue to pursue additional measures, through the Florida Legislature or alternative approaches, if necessary, to contain and resolve Florida's professional liability insurance crisis.

2. The FMA will intensify activities in the area of membership development with special appeals directed at women physicians, residents-in-training and medical students. This Program will:

 A. Recognize that membership **retention** is of equal importance to membership **recruitment**;

 B. Encourage the formation of county medical society membership development committees in accordance with Board of Governors policy;

 C. Motivate women physicians to participate more actively in organized medicine and to assume leadership roles in organized medicine at the county, state and national levels;

 D. Continue to work toward the goal of having every physician recognize the importance of a full commitment to membership at all levels of the medical Federation. The major source of strength of any organization is a strong membership, which demonstrates that the organization is truly representative of the grassroots and whose voice will thus be stronger.

3. A long-range public relations program intended to build and maintain a positive image of physicians will be developed and implementation will be undertaken in the most expedient manner possible within the Association's financial capabilities. The program will promote the private practice of medicine and remind the public of the benefit it derives from the cooperative alliance of the private and public health sectors. The program will include:

 A. Incorporation of the five-point public relations program developed by the American Medical Association into the Association's public relations activities.

 B. Encouragement of each county medical society to form a public relations committee or develop some other mechanism to supplement the FMA programs at the local level.

 C. Strengthening the FMA Speakers' Bureau and fostering the formation and function (through appropriate training programs) of similar bureaus within the county medical societies. Development and operation of ongoing leadership training programs for CMS officers.

 D. Development of appropriate programs to assist member physicians and their office staffs in improving communications and relationships with their patients.

 E. Coordination and integration of specialized public relations programs (e.g., the public health relations/education project) within the overall FMA public relations program, including allocation of staff time and fiscal resources.

 F. Assessment of the need for and, if appropriate, the development of a quarterly newsletter for members of the Florida Legislature, Florida's congressional delegation and other government officials as indicated.

 G. A plan for the rapid and accurate communication to news gathering organizations of the Association's reactions to news developments related to health care and the practice of medicine; and of the Association's views on current health care issues.

4. Additional steps will be taken toward full implementation of the Impaired Physicians Program with emphasis on identification and procurement of outside sources of funding; development of a harmonious and cooperative relationship with the Florida Department of Professional Regulation; and refinement of standards and procedures for approval or accreditation of participating treatment facilities.

5. The Association will strive for improvement in the internal communication of FMA news and other medical news to the branch offices, county medical societies, specialty groups and the membership through *The Journal*, the FMA monthly newsletter *FMA Today, The Legislative Bulletin, President's Memo* and other publications.

6. Members will be provided legal guidance through implementation of the telephone legal hotline, and a comprehensive reference guide to help physicians understand the requirements of state law as it applies to the practice of medicine will be developed and made available to FMA members. This publication will be periodically updated.

7. The Association will develop and present to the Department of Professional Regulation, through the Board of Medical Examiners, an acceptable plan for the FMA to administer the new statutory risk management and continuing medical education requirement. The Association will also assume responsibility for administration of the present FMA Mandatory CME program and will undertake to formulate and administer a comprehensive program of CME courses for FMA members.

8. The AMA/GTE Medical Information Network (MINET) will be marketed aggressively among the membership and the county medical societies.

9. Close surveillance will be maintained on the statewide peer review organization (PRO), and any evidence of irregularity or inequity will be documented and reported to the appropriate authorities.

10. The Medical Practice Act and all other health-related state laws that are scheduled to expire on October 1, 1986, will be scrutinized and appropriate recommendations regarding their re-enactment will be made to the Legislature.

11. The Association will continue to resist the unqualified efforts of allied health groups to intrude further into the practice of medicine through legislative and other means.

12. An aggressive medical economics program will continue to be pursued. Special attention will be given to implementation of Resolution 85-2 (Alternative Delivery Systems) and Resolution 85-4 (Workers' Compensation); development of a physicians contracting guide and the 1986 Relative Value Studies; examination of prepaid Medicaid plans; monitoring the development of the DHRS Primary Care Program; and generating recommendations regarding indigent care in Florida.

13. The FMA will develop a program to assure that each hospital medical staff exerts its proper influence in all care-related issues at its hospital.

14. Continued efforts to develop among FMA members an awareness of their individual responsibility for becoming actively involved, through organized medicine, in the decisions that will be made by the Legislature and other governmental bodies affecting the mechanisms and level of health care delivery in Florida and throughout the county including, but not limited to, health care financing and systems of health care delivery; i.e., Health Maintenance Organizations, Individual Practice Association, Preferred Provider Organizations, Diagnostic Related Groupings, health care competition, utilization review, peer review mechanisms, and other cost containment initiatives.

15. The FMA will cooperate with the Florida Physicians' Association in working to initiate positive programs supporting the intent of the House of Delegates at the time of generation of the Florida Physicians' Association.

16. The FMA will continue to pursue the implementation of the previous action of the Board to provide administrative services to specialty groups.

17. Pursue increased liaison with voluntary health organizations and consider development of objectives of mutual interest.

18. The FMA will continue its commitment to the quality and access for medical care for all citizens of Florida.

19. The Association will continue to actively support political education projects for FMA members on the state and national levels and continue to stress the importance of being knowledgeable in respect to the physician's role in the legislative process concerning health care issues.

Awards: The Board voted to continue the following FMA awards for 1986:

Excellence in Medical Journalism
Medical Speakers Awards
Medical Malpractice Prevention Award
Harold S. Strasser, M.D., Good Samaritan Award
Distinguished Layman Award

A.H. Robins Award: The Board reviewed nominations received from county medical societies and selected the recipient of the 1986 A.H. Robins Award "For Outstanding Community Service by a Physician." This award will be presented at the First Meeting of the House of Delegates on September 18, 1986.

Good Samaritan Award: The Board selected two outstanding physicians as recipients of the 1986 Harold S. Strasser, M.D., Good Samaritan Award for humanitarian acts above and beyond the high standard of conduct normally expected of physicians. These two physicians are not currently active members of the FMA nor retired. The Board felt, however, that they were well deserving of the award.

RECOMMENDATION C-1

THAT THE HOUSE OF DELEGATES WAIVE FOR 1986 THAT PORTION OF THE CRITERIA FOR THE HAROLD S. STRASSER, M.D., GOOD SAMARITAN AWARD WHICH REQUIRES THAT THE RECIPIENT(S) BE AN ACTIVE OR RETIRED MEMBER OF THE FMA.

HAROLD S. STRASSER, M.D., GOOD SAMARITAN AWARD CRITERIA

The 1983 House of Delegates established this award to be given annually from nominations received by county medical societies, FMA recognized specialty groups and hospital medical staffs. The recipient of this award must be an active or retired member of the Florida Medical Association. His or her nomination must cite and document a distinct act or acts of humanitarian and/or good samaritan activity, be above and beyond the high standard of conduct normally expected of physicians, and normally would not include devoted or loyal service to the recipient's own patients. Also, acts of humanitarian or good samaritan activity may be toward single individuals or groups of people. Each act cited should in some way demonstrate the recipient's love and compassion for his fellow man without concern for his/her own comfort, safety and welfare. Such examples might include rendering medical care voluntarily and without being asked to do so at the scene of an accident or disaster, and the leadership or active involvement in disaster relief efforts without regard to his/her own safety or welfare.

Certificate of Merit: The Board selected an outstanding physician for nomination to the House of Delegates to receive the Certificate of Merit for 1986 (the Association's highest honor of achievement). This nomination will be included in the Delegates' Packets for approval by the House of Delegates.

Certificate of Appreciation: The Board selected a physician to be nominated to the House of Delegates as recipient of the 1986 Certificate of Appreciation. this nomination will be included in the Delegates' Packets for approval by the House of Delegates.

Distinguished Layman Award: At the time of preparation of this report, the Board was still evaluating nominations from county medical societies for selection of the recipient of the 1986 Distinguished Layman Award. It is anticipated that a recipient for the 1986 award will be made in the near future. The appropriate citation, along with the criteria, will be included in the Delegates' Packets. This award will be presented at the First Meeting of the House of Delegates.

FMA Finances: A comprehensive report from the FMA Treasurer on the status of the Association's finances will be included in the Delegates' Packets and presented by the Treasurer to Reference Committee III. The following is a summary report and recommendations regarding the FMA's finances submitted by the Board for consideration by the House.

Income/Expenditures, 1985: The Association had a total income of $3,376,167 during 1985 from all sources including the following:

Dues and fees	2,642,371
FMA *Journal*	154,734
Directory and other publications	63,859
Technical Exhibits	13,240
Interest and Dividends	304,238
Special Services	26,689
Special Contracts	166,713
GTE/MINET Program	4,323
Total Income	3,376,167

Total expenditures during the year were $3,441,767 in the following categories:

General Activities:	942,888
Contract Services:	114,548
Administration:	625,452
Personnel:	1,474,351
Corporate Fund:	52,806
Unbudgeted but Authorized	231,722
Total Expenditures:	3,441,767

1986 Budget: The Board approved the proposed budget for 1986 with total anticipated income and expenditures of $3,912,000.

FMA Trust Fund: The House of Delegates in 1980 authorized the Board of Governors to establish a special trust fund for the current and future reserves of the Association, the initial funding coming from the approximately $600,000 profit from the sale of the headquarters building in Jacksonville. The Trustees of this fund are the three (3) immediate past living presidents of the Association, excluding the Immediate Past President who is an officer. The principal and interest of these funds accrue in this trust account which shall be established in the name of the Association in an escrow trust. The Trustees may release the funds upon request of the Board of Governors which indicates that an emergency exists which cannot be financed through regular income or assets of the Association. In the event the Trustees do not agree to release the funds, the Board of Governors may direct their release upon ¾ vote of the active members of the Board of Governors.

The net proceeds from the sale of the FMA property at 801 Riverside Avenue and the purchase of 760 Riverside Avenue left a net of $137,000 and, as directed by the Board, was placed in the reserve fund.

Payments on the mortgage are made annually in the amount of $166,257. The principal is applied to the trust fund and the interest to the FMA general revenue account. The interest earned through December 31, 1985, in the fund was $139,259 and the total balance in the trust fund as of December 31, 1985, was $680,723.

1984 FMA Assessment: The House of Delegates at a special called meeting on January 28, 1984, unanimously approved a mandatory assessment of $300.00 for all regular active dues paying members of the FMA to be utilized for implementing the FMA professional liability program. The assessment was billed on March 12, 1984, to 11,673 active members for whom the assessment was mandatory and to 2,866 members in other classifications, who were invited to pay the assessment on a voluntary basis. As of December 31, 1985, the deadline for payment of the assessment established by the House of Delegates, 10,509 active members have paid the assessment for a total of $3,152,700. A total of 750 voluntary payments were received for a total of $219,910.

In compliance with actions of the House of Delegates, these funds have been utilized solely for the FMA professional liability program.

Total expenditures from the assessment as of the date of this report were $3,272,044.41. The balance in the assessment account is $291,216.70.

In compliance with the directive of the House, 270 members were dropped from the FMA membership rolls effective January 1, 1986, for nonpayment of the assessment. Since that time 18 members have paid and have been reinstated as members in good standing.

FMA Income and Expenditures: The Board of Governors received an extensive report from the FMA Executive Committee regarding FMA future income and expenditures.

The Executive Committee in its capacity as the Finance Committee of the Association conducted an in-depth review of the Association's finances. The Committee considered an analysis of the FMA's financial position

prepared by the FMA Executive Vice President in consultation with the Treasurer. The Executive Committee also reviewed the previous actions and recommendations of the Executive Committee taken at its meeting in December 1984, which were subsequently approved by the Board of Governors at its meeting in January of 1985. (Appendix I)

During 1985 and into 1986, steps were taken to implement each of the recommendations approved by the Board. Considerable success has been achieved in constraining overall expenditures of the Association and in increasing overall income. This stabilization of the Association's finances was achieved in the face of potential severe negative financial implications due to the multiple problems which confronted the FMA during 1984.

It was noted that of equal importance to the positive financial changes that have occurred during the last 24 months have been the new directions set for the FMA under the leadership of that period.

The FMA's finances through mid-1986 overall reflect a continuing sound financial position. This is evidenced by an expanding and an increasing income base and controlled expenditures. There are, however, several areas of concern regarding the Association's current financial position.

1. The relatively low level of Association reserves. The FMA special trust fund currently stands at $700,162.73. Budgeted reserves for 1986 are $324,650 but will likely diminish by the end of the fiscal year. The desirable level of reserves should be one year's operating expenses which would be approximately $3 million.
2. The relatively slow growth in dues income which increases the importance of non-dues income. It is felt that dues income should comprise approximately 60-65 percent of total income from all sources.
3. The Association's ability to implement many of the important programs and activities of the Association are constrained by the current level of income. These include, but are not limited to:

 A. The ever expanding Association's legislative and political education and action activities at both the state and national level. A special committee of the FMA is currently conducting an in-depth review of the Association's legislative and FLAMPAC activities in an effort to build on the Association's achievements to date in these areas and to enhance our ability to become even more effective in the future. In addition, the FMA is actively working in cooperation with a broad-based coalition, the FCLR, relating to the professional liability problem in Florida as well as other areas of mutual interest.

 B. The FMA has made great strides in the last year in improving internal communications. The weekly publication of *E.T.* and *FMA Today* are examples of communications that have been implemented for the membership which have enjoyed tremendous success although at a considerable expense. Our efforts in this important area need to be continually enhanced.

 C. The physician's image is of vital concern at the state as well as the national level. The FMA has made every effort to expand its public relations activities within the constraints of its financial resources. There are a number of important recommendations from the FMA's public relations consultant and the public relations officer that have been approved by the Board of Governors to be carried out within the Association's financial capabilities.

 D. The medical legal hotline and the contract evaluations program are examples of activities that have been implemented through the Association's Medical Economics Department. In addition, the FMA is currently evaluating the appropriate role of the Association in the future with respect to alternative health care delivery systems and other medical economics issues.

 E. With the advent of mandatory continuing medical education including mandatory risk management programming, the Association is developing a program whereby the FMA can play a major role in administering these programs in the state of Florida.

 F. The impaired physicians program is rapidly growing and will require a continuing major financial commitment from the Association. We are also working to improve the quality of the FMA Leadership Conference and to develop ongoing leadership training programs for county medical societies' officers and other physicians involved in county medical society activities as well as the FMA. This would include the development of ongoing educational programs to include public speaking and leadership training in virtually all areas of activities of the Association.
4. Certain provisions in the FMA Bylaws discourage the prompt remittance of FMA dues by county medical societies. The current delinquent date of April 1 for dues has caused societies to withhold dues until late March. This has resulted in the loss of interest income to the Association of approximately $18,000 in 1986 alone.
5. The FMA has not increased its dues in five years (1982). Dues exempt members now constitute approximately 10 percent of the total membership and there has been no change in the dues for associate members since the 1960s ($50) nor in the entrance fee ($10) since 1948. The FMA is currently 37th in the country in the level of state dues.

RECOMMENDATION C-2
FMA DUES STRUCTURE

THAT THE HOUSE OF DELEGATES APPROVE AN AMENDMENT TO THE FMA BYLAWS TO PROVIDE FOR A MODIFICATION OF THE FMA DUES STRUCTURE EFFECTIVE JANUARY 1, 1987, AS FOLLOWS:

FMA ACTIVE MEMBERS	$300 (INCREASE OF $75)
FMA ASSOCIATE MEMBERS	$100 (INCREASE OF $50)
DUES FOR INTERNS, RESIDENTS AND MEDICAL STUDENTS	TO REMAIN THE SAME
FMA ENTRANCE FEE	$20 (INCREASE OF $10)

RECOMMENDATION C-3
DUES FOR EXEMPT MEMBERS

THAT THE HOUSE OF DELEGATES APPROVE A MODIFICATION TO THE FMA BYLAWS THAT WILL AUTHORIZE DUES FOR CURRENTLY EXEMPT MEMBERS (LIFE AND RETIRED) TO BE SET AT $50 PER YEAR EFFECTIVE JANUARY 1, 1988, PROVIDED THAT ANY MEMBER MAY SATISFY SUCH DUES REQUIREMENT FOR LIFE BY MAKING A ONE-TIME PAYMENT TO THE FLORIDA MEDICAL ASSOCIATION IN THE AMOUNT OF $1,000 EXCLUSIVE OF OTHER DUES AND ASSESSMENTS.

RECOMMENDATION C-4
DELINQUENT DATE AND DROP DATE FOR DUES

THAT THE HOUSE OF DELEGATES APPROVE A MODIFICATION OF THE FMA BYLAWS TO PROVIDE FOR A CHANGE IN THE DELINQUENT DATE FOR FMA DUES FROM APRIL 1 TO FEBRUARY 1 AND THE DROP DATE FROM OCTOBER 31 TO JULY 1.

RECOMMENDATION C-5
RESERVE POSITION

THAT THE HOUSE OF DELEGATES APPROVE IN PRINCIPLE THE GOAL OF ESTABLISHING A RESERVE POSITION FOR THE FMA AT A LEVEL THAT WOULD ALLOW THE ASSOCIATION TO OPERATE FOR ONE YEAR ON THE BASIS OF THE CURRENT YEAR'S OPERATING BUDGET.

Non-Dues Income: The Board of Governors authorized the continued development of additional appropriate sources of non-dues income for the Association including exploration of the proposal of a merger between Flamedco and Physicians Management Company for administration of the FMA's Insurance Programs and other appropriate activities.

Impaired Physicians Program: The Board of Governors authorized necessary contributions to the Florida Medical Foundation to ensure adequate funding for the impaired physicians program on the basis of recommendations from the FMA's certified public accountants as to the appropriate funding source of such contribution (FMA or Flamedco).

FMA Committee on Bylaws: The Board reviewed the report and recommendations of the Committee on Bylaws and took the following actions:

RECOMMENDATION C-6
MEDICAL STUDENT SECTION

THAT THE HOUSE OF DELEGATES APPROVE A MODIFICA-

TION TO THE FMA BYLAWS TO PROVIDE FOR THE ESTABLISHMENT OF A MEDICAL STUDENT SECTION WITH ONE VOTE IN THE FMA HOUSE OF DELEGATES.

RECOMMENDATION C-7
RESIDENT SECTION

THAT THE HOUSE OF DELEGATES APPROVE A MODIFICATION TO THE FMA BYLAWS TO PROVIDE FOR THE ESTABLISHMENT OF A RESIDENT SECTION WITH ONE VOTE IN THE FMA HOUSE OF DELEGATES.

RECOMMENDATION C-8
HOSPITAL MEDICAL STAFFS

THAT THE HOUSE OF DELEGATES APPROVE AMENDMENTS TO THE FMA BYLAWS TO INCLUDE PROVISIONS FOR THE COUNCIL ON HOSPITAL MEDICAL STAFFS TO DESIGNATE ITS DELEGATE TO THE FMA HOUSE OF DELEGATES, FOR FMA RECOGNIZED SPECIALTY GROUPS TO NAME THEIR DELEGATE TO THE HOUSE, AND FOR ESTABLISHING THE COMMITTEE ON MEMBERSHIP DEVELOPMENT AS A STANDING COMMITTEE.

Statewide IPA Study: The Board approved an immediate study by FMA in respect to the feasibility of the Association seeking to establish an FMA sponsored statewide prepaid health care plan.

Attendance at Board of Governors Meetings: The Board extended an invitation to county medical society presidents and executive directors to attend, at their own expense, all Board of Governors' meetings, including the Fall Meeting.

Medical/Legal Hotline: The Board approved guidelines for the implementation of the FMA Medical/Legal Hotline to be established effective July 1, 1986.

Medical Practice Act Licensure Exemption Law: The Board authorized the President and FMA Legal Counsel to explore the constitutional aspects of the Licensure Exemption Law passed during the 1985 Legislature.

County Medical Society Officers Advisory Council: The Board enthusiastically authorized the establishment of a council of all county medical society officers which will meet twice a year with the officers and/or Board of Governors of the FMA at the FMA Leadership Conference and the FMA Annual Meeting for the purpose of discussing issues affecting organized medicine.

Ad Hoc Committee Re: FMA and FMA-A Activities, Key Contact Physician Program and FLAMPAC: The Board authorized the President to appoint an ad hoc committee to study the relationship between the FMA and the FMA-A to consider ways the Auxiliary's role in FMA activities might be enhanced and further to review the FMA state and national key contact physician program for the purpose of evaluating its effectiveness with appropriate modifications as may be indicated and, further, to review the integral relationship and goals of the FMA, the FMA-A and FLAMPAC.

FMA Today: The Board of Governors authorized FMA's monthly newspaper, *FMA Today*, be distributed to all licensed physicians in the State of Florida as a membership development technique and that it also be distributed to the editors of all Florida newspapers, members of the Florida Legislature and Cabinet and the Florida Congressional Delegation.

Physician Licensure Renewal: The Board discussed the growing problem regarding severe penalties being imposed by the Department of Professional Regulation on physicians who are tardy in renewing their license to practice medicine in the State. It was noted that a part of the problem is caused by the Department's failure to make any attempts to locate those physicians who may have changed their address. The Board requested that Dr. Webster, the SBME representative on the Board, discuss this matter with the Board of Medical Examiners and request that they notify county medical societies and the FMA regarding physicians who have not renewed their license. The Board also requested the FMA to work with DPR in seeking an expeditious resolution to this problem.

AMA Task Force on Professional Liability: The Board of Governors also enthusiastically endorsed the nomination of Frank C. Coleman, M.D., to the AMA Task Force on Professional Liability and Louis C. Murray, M.D., to the Council on Legislation.

ASIM Internist of the Year: The Board enthusiastically endorsed the nomination of Robert E. Windom, M.D., as the recipient of the American Society of Internal Medicine Internist of the Year Award.

AMA Health Agenda: The Board authorized FMA financial assistance of $2,500 in support of the implementation and promotion of the Health Policy Agenda for the American People which is expected to be finalized by January 1, 1987.

Florida Physicians Association

Newly Elected Officers: Received an informational report from the Florida Physicians Association in respect to newly elected officers. The following were elected:

Charles J. Kahn, M.D., President
John A. Dyal Jr., M.D., Vice President
Miguel Figueroa, M.D., Secretary
Warren M. Barrett, M.D., Treasurer

Collective Bargaining: Received a report that the FPA was investigating the legalities affecting the FPA in serving as a third party collective bargaining agent for the Association's members.

The Board approved a four-part plan to be undertaken by the FPA in respect to this issue:

1. To co-sponsor with the FMA a workshop on physician unionization and collective bargaining at the FMA Leadership Conference.
2. To send a letter to all FPA members explaining the physician unionization issue. The letter would also be sent to all FMA non-FPA members with the next FPA dues notice.
3. To prepare in conjunction with FMA a contracting guide and materials on how to negotiate effectively.
4. To develop possible changes to Federal law that would allow physicians to collectively bargain.

Contract Negotiation Service: The Board received a preliminary report from the Florida Physicians Association regarding a possible contract negotiation service to be offered by the FPA to its members. The service would provide for trained negotiators to represent individual physicians in contract negotiations with HMOs and other prepaid health plans, and hospitals. The Board encouraged the FMA to move toward finalization and implementation of such a program at the earliest possible date.

Committee on Peer Medical Utilization Review

Operating Procedure: The Board approved the recommendation that the operating procedures of the Peer Medical Utilization Review Committee be revised to place restrictions on the state and county review committees for the time involved in conducting peer review in order to preserve the two-tiered level of peer review.

These changes are necessitated by severe budget cutbacks by HCFA, being imposed on Blue Cross/Blue Shield, the fiscal intermediary for Medicare. The cutbacks directly affect the amount of funding that is available for the PMUR Program. Last March a moratorium was placed on all reviews except for appeals until the budgetary problems could be resolved.

Contract for Medicare Peer Review: The Board authorized the Committee on PMUR to perform Medicare Peer Review for Blue Cross and Blue Shield of Florida at a flat rate of $1225 per case. The Board also authorized a limit on county medical society peer review administrative and professional expenses for peer review activities. The Board further approved a modification in the Foundation's operating procedures eliminating a provision for reimbursement of representatives of county medical societies to attend state PMUR committee meetings.

Report of Public Relations Officer

Future Activities: The Board received an in-depth report from the Public Relations Officer on current, short-term and long-range public relations activities of the Association. A broad-based and ongoing public relations program is being developed and will require a major long-term commitment by the Association in both time and financial resources. Moreover, it will only be successful if it is properly coordinated with the AMA (see item re

AMA public awareness campaign) and FMA component medical societies and specialty groups and, perhaps most important, if individual physicians are willing to participate as an integral element of any program. The program must begin and end in the physician's office or his/her contact with people in any setting. The most effective public relations comes from the grassroots level. Physicians must become more aware of their individual image, particularly in the area of patient relationships. If physicians are alienating their patients, our public relations program will be facing an uphill battle. Therefore, a top priority will be to develop training programs in patient relations for physicians and their office staffs.

Efforts will be made to organize a panel of physicians from differing specialties to discuss patient relationships and varying problems of the office practice and physician/patient relationship. If the major real or perceived problem areas can be identified, we will be better equipped to design a more effective educational or behavioral-type program.

Some preliminary ideas as to the methods of developing a patient relations training program for physicians include:

- A program for either the next Leadership Conference or Annual Meeting
- Develop a program which the county medical societies could administer
- Develop periodic columns on the subject for the Association's monthly newsletter, *FMA Today*, and *The Journal* of the FMA

Another potential area for development at the grassroots level is communicating messages to patients in the physician's office waiting room. The FMA is exploring the possibility and feasibility of initiating a mechanism whereby physicians could, at a reasonable cost, install VCRs in their waiting rooms. These would be used to show a variety of medical programming or medical-related issues to patients waiting to see their physician. The FMA would develop programs for video taping as well as use existing materials. This is a long-range project which will require in-depth study and investigation before implementation.

Another area of activity is the publishing of a quarterly newsletter targeted for state legislators and the Congressional Delegation and other selected government officials. Through this newsletter, FMA would seek to keep legislators and government administrators updated and informed about medical issues impacting physicians and the general public.

Developing speakers bureaus at the county medical society level is an important priority as well as developing some young, dynamic physicians to be spokespersons. The FMA will work with the AMA Communications Department to develop a mechanism for conducting speaker's training courses in Florida on an ongoing basis.

RECOMMENDATION C-9
BYLAWS AMENDMENTS

THAT THE HOUSE OF DELEGATES ADOPT THE FOLLOWING AMENDMENTS TO THE FMA BYLAWS:

Amendment: Provides for the establishment of a Medical Student Section and Resident Section.

Chapter VIII
COUNCILS AND SECTIONS.

Section 4. The House of Delegates shall have the authority to create special Sections for the purpose of organizing members with identifiable common and unique interests. The Board of Governors shall specify the composition, form and function of each special section as created. Membership in a special section shall be limited to those holding a membership in the FMA and a component medical society.

A. There shall be a special section for medical student members of the Florida Medical Association. The Medical Student Section shall be entitled to one voting member in the FMA House of Delegates provided such delegate shall be a member of the Medical Student Section and the FMA.

1. The Medical Student Section shall be organized pursuant to bylaws approved by the FMA Board of Governors.

2. There shall be a business meeting of the medical student members of the FMA annually. The business meeting shall be held on a day prior to the Annual Meeting of the FMA House of Delegates at time and place to be designated by the FMA Board of Governors.

3. The Medical Student Section may adopt resolutions for submission and consideration to the House of Delegates of the FMA.

B. There shall be a special section for Residents of the Florida Medical Association. The Resident Section shall be entitled to one voting member in the FMA House of Delegates provided such delegate shall be a member of the Resident Section and the FMA.

1. The Resident Section shall be organized pursuant to bylaws approved by the FMA Board of Governors.

2. There shall be a business meeting of the Resident Section members of the FMA annually. The business meeting shall be held on a day prior to the Annual Meeting of the FMA House of Delegates at a time and place to be designated by the FMA Board of Governors.

3. The Resident Section may adopt resolutions for submission and consideration to the House of Delegates of the FMA.

Amendment: Provides for the recognition of new delegates in the House of Delegates; reporting of credentials and alternate delegates.

Chapter IV
HOUSE OF DELEGATES

Section 1. Designation and Composition.
The House of Delegates is the legislative and business body of the Association, and its members are the delegates officially elected by the component societies, specialty societies, Hospital Medical Staffs Council, Medical Student Section, and Resident Section, in accordance with the provisions of these Bylaws, ~~one member of the Hospital Medical Staffs Council appointed in accordance with the provisions of these Bylaws,~~ and Speaker and Vice Speaker of the House.

Section 6. Determination of Delegates.
~~The student members of a component medical society with whose jurisdiction a school or college of medicine is located shall be entitled to select annually one delegate. This delegate must be approved by the county medical society and will be in addition to those chosen to represent regular members as provided elsewhere in these Bylaws.~~

Each specialty society recognized by the FMA, The Council on Hospital Medical Staffs, the Medical Student Section and the Resident Section shall be entitled to select annually and send to each meeting of the House of Delegates one delegate who shall be entitled to one vote. No delegate may represent more than one organization entitled to representation in the House of Delegates.

Section 10. Delegates Credentials.
~~The Secretary of each~~ Each component society, Specialty Society and other organizations authorized to send Delegates to the House of Delegates shall notify the Secretary of the Association which of its members have been selected ~~by the society~~ as delegates to the House of Delegates of the Florida Medical Association as soon as practicable after their election, but not later than June 1 preceding the Annual Meeting. Each delegate so elected shall be a member of the FMA in good standing ~~in his component society~~ and shall have paid his current Association dues and assessments.

Section 12. Alternate Delegates.
Each component society shall select alternate delegates corresponding in number to the delegates to which it is entitled, and shall designate to the Secretary of the Association the order in which they are to serve. Each specialty society, the Council on Hospital Medical Staffs, the Medical Student Section, and the Resident Section entitled to have a delegate shall be entitled to select one alternate delegate to serve for its delegate.

Amendment: Provides for authorization of the Council on Hospital Medical Staffs to select its delegate to the FMA House of Delegates from the Council membership.

Chapter VIII
COUNCILS

Section 3. Duties, Functions and Composition.
7. **The Council on Hospital Medical Staffs** shall consist of nine members, two from each of the four medical districts and a Chairman appointed by the President. The district member shall be appointed by the Board of Governors from nominations received from the component county medical societies. Each member shall serve a one-year term and may be renominated and reappointed. Council members must be members in good standing of the Florida Medical Association. The Council shall provide representation of hospital medical staffs and shall maintain liaison with and serve in an advisory capacity to hospital medical staffs around the state. It shall provide at least twice annually an opportunity for hospital medical staffs to meet with the Council to discuss common issues and concerns. At each such meeting, one representative from every hospital medical staff within the state of Florida shall be invited. One of those meetings shall be held in conjunction with the Annual Meeting of the Florida Medical Association. The Council shall strive to increase its awareness of and to communicate to the Association the issues that are affecting physicians as members of hospital medical staffs. It shall provide a vehicle to identify the implication of future trends and the role of physicians individually and as members of medical staffs. It shall develop and maintain information on issues of common concern to medical staffs and distribute data on successful approaches to problems. Council members shall consider all matters referred to it by the House of Delegates or President of the Florida Medical Association. The Council shall be entitled to send to the FMA House of Delegates one Delegate from the Council who shall be selected by the members of the Council and who shall also be a member of the FMA. ~~In order to ensure that hospital medical staffs are adequately represented, one member of the Council shall also, by virtue of appointment to the Council, become a voting delegate to the House of Delegates.~~

Amendment: Provides for the creation of the Council of County Medical Society Officers.

Chapter VIII
COUNCILS

Section 1. Organization.
Directly responsible to and reporting through the Executive Committee to the Board of Governors shall be the following Councils:

1. Judicial;
2. Legislation;
3. Medical Economics;
4. Medical Services;
5. Scientific Activities;
6. Specialty Medicine;
7. Hospital Medical Staffs;
8. County Medical Society Officers.

Section 3. Duties, Functions, and Composition.
8. The Council of County Medical Society Officers shall consist of the officers of the respective component county medical societies and shall meet with the officers of the Florida Medical Association two times a year at the FMA Leadership Conference and the FMA Annual Meeting for the purpose of discussing issues affecting organized medicine.

Amendment: Provides for the elimination of the 250 cap on delegates while maintaining the one delegate for every 40 active members of the FMA within each county medical society.

Chapter IV
HOUSE OF DELEGATES

Section 6. Determination of Delegates.
~~The House of Delegates shall be limited as nearly as possible to a maximum of 250 regularly elected members from county medical societies, and one student delegate from such component society in whose jurisdiction a college or school of medicine exists. The Board of Governors shall automatically determine the ratio of delegates to active members to accomplish this limit of the membership of the House.~~

Amendment: Provides for the designation of the Committee on Membership Development as a standing committee of the FMA.

Chapter IX
COMMITTEES

Section 3. Duties and Functions.
5. The Committee on Membership Development shall be responsible for the ongoing development and retention of members at the local, state, and national level. The Committee shall coordinate its activities in cooperation with the component county medical societies and the American Medical Association.

Amendment: Provides for the shortening of the length of time in which dues shall be submitted to the FMA.

Chapter X
INCOME AND EXPENDITURES

Section 2. Dues.
2. Entrance Fee.

Each new active or associate member, except student members, shall be required to pay an entrance fee of ~~$10.00~~ $20.00 in addition to his annual dues.

Medical student members will pay a $10.00 fee at such time as they are eligible for reclassification of membership.

5. Delinquency.

An active or associate member whose annual dues have not been received by the Association through his component society on or before ~~April 1~~ February 1 of the current year shall be considered delinquent. He shall be notified of such delinquency by the Secretary of the Association by letter mailed to his last known address. If payment has not been received on or before ~~October 31~~ July 1 of that year, he shall be summarily removed from the membership roll of the Association.

Amendment: Provides for the elimination of the specific prohibition currently in the Bylaws that exempts life members from all dues and assessments.

Chapter I
MEMBERSHIP

Section 2. Classifications.
2. Life Members.

Any member who has been an active member of the Association for thirty-five years or who is a Past President of the Association shall automatically qualify to become a life member. ~~and be exempt from all Association dues and assessments as long as he maintains membership in a component society.~~

Coding: Words underlined are additions; words ~~stricken~~ are deletions.

Report F
Supplement to Report C
of the
Board of Governors

Report F, Supplement to Report C of the Board of Governors was adopted.

The Reference Committee considered the Report regarding the disposition of those items considered by the 1985 FMA House of Delegates referred to the Board of Governors for additional study and/or action. The Reference Committee noted that Resolution 85-4, on page F.2, was referred to Reference Committee V; Resolution 85-12, on page F.3, was referred to Reference Committee IV; Resolution 85-17, on page F.3, was referred to Reference Committee II; Resolution 85-19, on page F.3, was referred to Reference Committee IV; Resolution 85-23, on page F.4, was referred to Reference Committee II; and that Resolution 85-24 and 85-25, on page F.4, was referred to Reference Committee IV.

The Recommendation of the Reference Committee that the Board of Governors Report F regarding 1985 House of Delegates referrals be accepted as information, except those items referred to other Reference Committees was filed.

The Reference Committee heard extensive testimony regarding the report and recommendation of the Judicial Council, chaired by Dr. Joseph H. Davis, regarding the grievance procedures proposed by the FMA Judicial Council for the FMA and component county medical societies. The Reference Committee acknowledged the importance of comprehensive, expedient and equitable procedures in handling grievances filed against physicians. The Committee commended the Judicial Council for its extensive work in developing an effective mechanism to ensure that prompt and fair actions are taken in every case. However, it was clear from the testimony presented to the Reference Committee that there is wide disparity in the grievance process among county medical societies. There was also considerable confusion and concern regarding some of the Council's recommendations in that they would impose a time frame on some county medical societies for which they do not have the current capability for compliance. The Reference Committee felt that this issue was of such timely and significant importance that a negative action by the House of Delegates would not be in the best interest of the FMA and its component societies and the public.

The Reference Committee moved that Recommendation No. F-1 be referred to the Board of Governors for additional review including input from component county medical societies and that recommendations regarding grievance procedures be submitted to the House of Delegates at its next meeting.

Then Dr. Margaret C.S. Skinner moved to amend the motion to read that Recommendation No. F-1 be referred to the Board of Governors for additional review including input from component county medical societies, and that a comprehensive plan for grievance procedures be created and implemented by the Board of Governors as rapidly as possible. The motion was adopted as amended.

Recommendation No. F-2 was adopted as presented.

Recommendation No. F-3 was adopted as presented.

The Reference Committee recommended that Recommendation No. F-3, Nominations for Election to the Committee on Membership and Discipline, be adopted with the exception of District 9 which includes two nominations requiring election by the House of Delegates by ballot. Recommendation No. F-3 was adopted as presented with the exception of District 9.

Recommendation No. F-4 was adopted as presented.

Report F
Supplement to Report C
of the
Board of Governors

1985 House of Delegates Referrals

The Board reviewed the proceedings of the House of Delegates and items and resolutions requiring additional study and/or action were referred to the appropriate councils and committees. The Board also revised resolutions not adopted by the House but referred to the Board for review.

The following report summarizes the status of the actions taken by the Board regarding each of these items. In addition, actions regarding the policies of the House of Delegates appear in the various council and committee reports as well as in this and other reports of the Board of Governors in the Delegates' Handbook.

RESOLUTION 85-1
Public Relations Programs
Duval County Medical Society

RESOLVED, That the Florida Medical Association immediately develop a long-range program of public relations and positive physician image building, which is adequately funded and professionally staffed; and be it further

RESOLVED, That each county medical society be encouraged to establish a local public relations committee; and be it further

RESOLVED, That said long-range program of public relations be established in coordination with local county medical societies in order to maximize available talent and resources.

RESOLUTION 85-10
Educational Advertising Campaigns
Dade County Medical Association

RESOLVED, That the Florida Medical Association immediately implement a statewide educational advertising campaign promoting the private practice of medicine, and that this campaign continue until the 1986 Annual Meeting; and be it further

RESOLVED, That if additional funds are needed, each member be assessed a fair and appropriate amount, or the Association dues structure be amended to allow for this campaign.

Upon the motion of the Reference Committee, both Resolutions 85-1 and 85-10 were considered together. These resolutions were not adopted but referred to the Board of Governors for review.

Long Range Planning: Immediately after the 1985 Annual Meeting, the Board of Governors began working with public relations consultant Roy Pfautch to develop a long-range public relations program. Mr. Pfautch presented a program outline to the Board of Governors at the September, 1985, meeting. Due to budgetary constraints, the FMA Executive Committee has moved cautiously in respect to entering into new public relations programs during 1986. However, several public relations programs are under consideration and will be implemented when necessary and adequate funding becomes available.

(Please refer to the report of the public relations officer included in the Delegates' Handbook.)

CMS Assistance: The FMA Communications staff has offered assistance to county medical societies in establishing public relations committees and speakers bureaus. Currently, 20 county medical societies have either a public relations committee or a speakers bureau. FMA sponsored two speakers training courses in Tampa on November 20-21 and in Miami on November 23-24. FMA has under consideration a plan to hire a part-time person skilled in speaker training who will be available to travel to county medical societies and conduct training courses on an ongoing basis.

Statewide Educational Advertising Campaign: The FMA Communications staff is available to county medical societies on a consultant basis for information and assistance in starting either public relations committee or speakers bureau.

The Executive Committee has considered three reports from its public relations officer in respect to implementing a statewide educational advertising campaign promoting the private practice of medicine. The Executive Committee, considering the magnitude of such a program, felt that it would be inappropriate at this time to assess the membership to fund such a campaign. As is outlined in other sections of this report, it should be noted that the Executive Committee and the Board of Governors is recommending to the membership a dues increase. Certainly such additional funds will be helpful in funding these types of aggressive and costly advertising campaigns.

In addition, the Board is looking into the possibility of adapting a physician image program developed by the American Medical Association. This program centers around a physician profile film which depicts physicians in a variety of professional and geographic settings. The primary focus of this file is on the many changes occurring in American medicine today and how physicians serve as caring advocates for their patients' rights. The film will be available for viewing during the FMA Annual Meeting.

RESOLUTION 85-2
Alternative Delivery Systems
Duval County Medical Society

RESOLVED, That the Florida Medical Association place more emphasis on providing information to its membership regarding alternative health delivery systems and develop a strategy and plan of action that can be used by physicians individually or collectively in competing with said systems; and be it further

RESOLVED, That funding and staffing be added to bring this program into fruition as soon as possible.

This resolution was not adopted but referred to the Board of Governors for review.

Actions by Council on Medical Economics: As a result of this resolution, the FMA Council on Medical Economics recommended the creation of the Contract Evaluation Section of the Medical Economics Department having the main purpose of reviewing provider contracts offered by various prepaid plans. Information concerning various prepaid operating plans has been maintained by the Medical Economics Department and made available to the membership upon request. Pursuant to the direction of the Council on Medical Economics and in cooperation with the Florida Physicians Association, a "Physician Contracting Guide" to aid physicians in negotiating prepaid plans was completed and distributed to every member of the Florida Medical Association.

Statewide IPA Feasibility Study: During the September, 1985, meeting, the Council on Medical Economics developed a feasibility study on prepaid plans. An analysis was prepared on the current development of alternative delivery systems, and a letter was sent to all existing operating HMOs and PPOs in the state requesting specific information about their operations. In addition, a letter was transmitted to each county medical society asking for comments or suggestions in respect to the FMA conducting a feasibility study regarding the establishment of a statewide prepaid plan. Every state medical association was polled regarding their activities pertaining to prepaid health plans and whether they were considering developing a statewide IPA similar to the Medical Association of Georgia. A legal opinion was obtained regarding the legal implications of the FMA establishing a statewide prepaid health care plan and the structure of individual practice associations.

Twenty-three component county medical societies, representing approximately 12,000 FMA members, responded to the questionnaire that was submitted. As a result of this study, the Council on Medical Economics offered several options to the FMA Board of Governors. Subsequently, at the October, 1985, meeting, the Board of Governors approved development of an Ad Hoc Committee on Prepaid Plans. This Committee, chaired by Frank C. Coleman, M.D., was given the charge of studying the current prepaid plan activity situation in Florida and developing recommendations to the Board on how the FMA could better participate in this type of activity.

Continued Activities: The Ad Hoc Committee on Prepaid Plans, as well as the Council on Medical Economics, have continued to study various alternatives and options for actions in the future. FMA has retained Judith Mattson of Judith Mattson, Inc., a consulting firm located in Bethesda, Maryland, who has expertise in the area of prepaid health plans and was the consultant to the Medical Association of Georgia plan. It is anticipated that the Ad Hoc Committee on Prepaid Plans will continue to be active in developing recommendations and formulating policy with regard to prepaid plan activity.

RESOLUTION 85-4
Workers' Compensation Medical Fee Schedule
Dade County Medical Association

RESOLVED, That this matter be a sponsored priority in seeking legislative relief; and be it further

RESOLVED, That the Florida Medical Association immediately retain competent legal counsel knowledgeable about Workers' Compensation laws, for purposes of legal or other actions against the appropriate party or parties to accomplish the goals of Resolution 83-7; and be it further

RESOLVED, That all county medical societies be informed of the progress and status of this situation on a timely basis.

A substitute resolution to Resolution 85-4 was offered by the Reference Committee and adopted by the House of Delegates and referred to the Board of Governors.

RESOLVED, That legislation revising the workers' compensation reimbursement system be sponsored by the Florida Medical Association and be given a high priority; and be it further

RESOLVED, That the Florida Medical Association immediately retain expert legal counsel knowledgeable about workers' compensation laws for purposes of legal or other actions against the appropriate party or parties to accomplish the goals of Resolution 83-7; and be it further

RESOLVED, That all county medical societies be informed of the progress and status of this situation on a timely basis.

Committee on Worker's Compensation Actions. The Committee on Workers' Compensation of the Council on Medical Economics, chaired by Howard A. Kurzner, M.D., presented testimony before the Three Member Panel on February 6, 1986, in Tallahassee supporting the establishment of an increase in the workers' compensation fee schedule. FMA has experienced resistance in the Three Member Panel in the past in asking for increases in the workers' compensation fee schedule. During the 1984-85 Association year, a 4.2 percent increase was granted. During the 1985-86 Associa-

tion year, the FMA was granted a 3.1 percent increase representing a 7.3 percent increase over a two-year period.

Consultant Retained: The Board authorized that an outside consultant be retained. Mr. John Lewis, Esquire, an attorney consultant in the field of workers' compensation with excellent credentials was retained to assist with this issue at a cost of $15,000.

Mr. Lewis has just completed a preliminary report in respect to his analysis of the current workers' compensation medical surgical system and his recommendations for legislative changes to that system. It is anticipated that a final report from Mr. Lewis will be forthcoming shortly and the recommendations in respect to that report will be provided to the membership through *E.T.* and *FMA Today*.

RESOLUTION 85-7
Relocation of FMA Headquarters
Dade County Medical Association

RESOLVED, That a committee composed of equal representation of each FMA district be created to conduct a feasibility study regarding the relocation of the Association headquarters to a more accessible location; and be it further

RESOLVED, That said report be presented to the 1986 meeting of the House of Delegates.

This resolution was not adopted but referred to the Board of Governors.

Upon consideration of the intent of the resolution, the Board referred this matter to the Executive Committee for evaluation and recommendations.

The FMA Executive Committee, which serves as the Association's finance committee and long-range planning, reviewed Resolution 85-7 in conjunction with an indepth review of the Association's finances. The results of that review are reflected in the Board of Governors' recommendations to the House of Delegates relating to the Association's finances. The Executive Committee did not feel that an extensive review of the resolution was feasible at this time given the Association's current financial status. The Executive Committee did receive as information the following initial observations.

- The cost of relocating the FMA to another location in the state would be very costly and possibly prohibitive and simply not affordable at the present time.
- There would be a potential, substantial loss of experienced and valued FMA personnel. In addition, the FMA supervises the operations of two subsidiary companies, Flamedco and Centurian Press, Inc. The services and products of both these companies are an integral part of the FMA's activities and an important element of the Association's finances.
- The FMA has four regional offices which it shares with the Florida Physicians Insurance Company (FPIC) to serve the expansive geographical area of Florida.
- The location of the FMA office does not appear to be a negative factor affecting meetings and activities of the Association. The FMA has traditionally rotated all of its meetings throughout the state to allow for broader participation in the Association's activities.
- Interstate air transportation to and from Jacksonville has improved significantly and is projected to continue because of the rapid growth being experienced in Northeast Florida. In addition, meeting facilities in the area are increasing rapidly.
- The Florida Physicians Insurance Company (FPIC) sponsored by the FMA, which is headquartered in Jacksonville with 44 employees, has expressed an interest in participating with the FMA in the purchase of new office space in Jacksonville for shared occupancy. In addition, FLAMEDCO and Centurian Press, Inc., employing a total of 38 people could also be housed in such a facility. This would result in the consolidation of FMA related activities as will generate additional income to the Association in the form of rental income.

The Executive Committee will keep Resolution 85-7 under review and submit recommendations to the Board in a manner that is timely and fiscally prudent for subsequent recommendations to the House of Delegates.

RESOLUTION 85-8
Expert Testimony Requirement
Dade County Medical Association

RESOLVED, That the Florida Medical Association take immediate action to promote the passage of state legislation requiring that any physician offering expert testimony in any malpractice case in Florida be licensed to practice in the state and be familiar with the medical practices in the community where the alleged malpractice occurred.

This resolution was not adopted but referred to the Board of Governors.

1985 Legislation Addresses this Issue: In the 1985 session of the Florida Legislature, a provision of the comprehensive medical malpractice and reform act address expert testimony by health care providers. This particular provision is one of the most far reaching changes in the law and is a change in the definition of the doctor's standard of care. The prior law defined the standard as "the acceptable standard of care." The new law provides that the standard care is the "prevailing professional standard of care." This definition change is an attempt to recognize the degree of discretion inherent in diagnosis, care and treatment of patients by different health care providers. The law expands the type of similar health care provider who could testify as an expert in a case but also limits expert witnesses to those with active involvement in the practice or teaching of medicine in the same or related fields within a five-year period prior to the alleged incident. If the accused doctor is board certified, the expert who testifies against that doctor must be one who is trained and experienced in the same specialty and is certified by the same board. If, however, the accused doctor is being sued for an incident that arose out of a treatment or diagnosis for a condition which is not that doctor's specialty, the expert witness may be one who is trained in the treatment or diagnosis of the condition that the doctor was treated.

RESOLUTION 85-9
Mandatory FMA Membership
Dade County Medical Association

RESOLVED, That the Florida Medical Association seek passage of legislation mandating membership in the Florida Medical Association as a prerequisite for maintaining a Florida medical license and for hospital staff privileges with reference to Doctors of Medicine and osteopathy; and be it further

RESOLVED, That the Florida Medical Association seek passage of legislation allowing for some autonomy of state and local medical societies in disciplining their members.

The resolution was not adopted but referred to the Board of Governors.

Actions by the Council on Legislation. The Council on Legislation has evaluated this recommendation and has advised the Board of Governors that this is a difficult and comprehensive matter that would require a great deal of research and legislative discussion prior to introduction of such legislation. Because of the time, energy and resources allocated to the pursuit of meaningful tort reform during the last two legislative sessions and which was a major issue in 1986, the Council on Legislation has felt that this matter should best be addressed in future legislative sessions. Moreover, it is the Council's opinion that such legislation will need to be explored thoroughly in respect to the ramifications passage of such law might have on FMA members and non-members.

RESOLUTION 85-12
Limitations to Medical Malpractice Liability
Dade County Medical Association

RESOLUTION 85-16
Workers' Compensation Approach to Medical Liability Insurance
Lee County Medical Society

RESOLVED, That medical liability on a no-fault and "workers' compensation" basis, with pre-determined limits of liability, be endorsed as a viable alternative to the present tort system.

The House of Delegates combined these two resolutions into the above substitute resolution. This resolution was not adopted but referred to the Board of Governors.

1986 House of Delegates Action: Pursuant to this resolution, the Board of Governors recommended to the House of Delegates at the 1986 FMA Interim Meeting that the FMA support the development and passage of legislation which provides for resolving medical malpractice claims through a system which brings about resolutions for such claims outside the current civil litigation process. The Council on Legislation has undertaken to study the details of such a program and has worked with several legislators who have offered such a program. It appears that such an alternative approach will be seriously considered by the Academic Task Force on Tort Reform and insurance reform which was created by the 1986 Legislature. The FMA is continuing to pursue this goal on a long-term basis.

RESOLUTION 85-14
Florida Physicians Association
Broward County Medical Association

RESOLVED, That the Florida Medical Association Board of Governors request the Florida Physicians Association to initiate positive programs supporting the intent of the House of Delegates at the time of generation of the Florida Physicians Association.

The resolution was not adopted but referred to the Board of Governors.

FPA Activities: The Board of Governors has reviewed the resolution and referred the matter to the Florida Physicians Association for its comments. FPA reports that within the last year, they have initiated several positive programs. In cooperation with the FMA, the FPA published the "Physicians Guide to Contracting." This booklet was distributed to all members of the FPA and the FMA at no charge.

FPA conducted detailed legal research in the anti-trust implications for physicians collectively bargaining and then co-sponsored a seminar on unionization at the annual FMA Leadership Conference in February of 1986. The seminar focused on the likely violations of federal laws that would result if non-employed physicians attempted to take effective action against HMOs, PPOs, IPAs, hospital, etc. Lastly, the FPA is in the process of exploring a contract negotiation service. This service would assist physicians considering contracting with HMOs, IPAs, PPOs, hospitals or other entities by providing expert, trained negotiators to assist the physician. The negotiators would, upon request of a member, review an offered contract; discuss the contract with the physician; determine the changes desired by the physician; and negotiate for the desired changes on behalf of the physician with the appropriate personnel representing the contracting entity. It is anticipated that this service would be made available only to FPA members.

RESOLUTION 85-17
All Terrain Vehicles (ATV) Injury
Collier County Medical Society

RESOLVED, That the Florida Medical Association undertake a strong campaign to educate the public regarding the serious dangers of all terrain vehicles (ATV) through the electronic and printed media as well as programs in the schools.

The resolution was adopted and referred by the House of Delegates to the Board of Governors for determination of fiscal impact.

Limited programs to alert the general public to the serious dangers of all terrain vehicles is being conducted within the fiscal constraints of the Association. An initial story on this subject appeared in the January, 1986, issue of *FMA Today* and another story is planned for the September issue. Additionally, a medical message of ATVs will be mailed to all Florida newspapers in September.

RESOLUTION 85-19
SBME Licensure Renewal Procedure
Polk County Medical Association

RESOLVED, That the FMA seek legislation mandating interaction between the administrative staff of the Board of Medical Examiners and the FMA prior to voiding or inactivating a physician's license due solely to a physician's failure to respond to mailings that may never have been received due to difficulties with mailings; and be it further

RESOLVED, That the FMA establish a process similar to the Continuing Medical Education required notification which will ensure the relicensing of FMA members on a timely basis.

This substitute resolution was adopted and referred to the Board of Governors.

RESOLVED, That the Florida Medical Association seek establishment of appropriate mechanisms that would enable the FMA to contact physicians and their county medical societies when a medical license has not been renewed.

Pursuant to the direction of the House, the Board of Medical Examiners was contacted and has agreed to provide the FMA with a list of those physicians delinquent in renewing their licensure. FMA will then notify the county societies so that these physicians can be contacted in time to avoid inadvertent invalidation of their medical practice license.

RESOLUTION 85-23
Pre-School Physical Examinations
Duval County Medical Society

RESOLVED, That the Florida Medical Association opposes the performance of pre-school health examinations by chiropractors and other limited care practitioners as being contrary to the best interests of the school children of Florida; and be it further

RESOLVED, That the Florida Medical Association believes that the pre-school examination is of such importance to the health and well-being of children that only an examination and certification performed and signed by a qualified Doctor of Medicine or Doctor of Osteopathy should be accepted by local boards of education; and be it further

RESOLVED, That the Florida Medical Association work with its county medical societies and recognized specialty groups, the Florida Osteopathic Medical Association, state government agencies and local school boards to develop programs that will make a pre-school examination by a qualified practitioner available to every school child; and be it further

RESOLVED, That the Florida Medical Association adopt as part of its legislative program further amendment to Section 232.0315(1), Florida Statutes, to specify that local school boards may accept health certifications signed only by physicians licensed or as defined as Chapter 458 and Chapter 459, Florida Statutes.

This resolution was adopted by the House of Delegates and referred to the Board of Governors for implementation.

Council on Legislation and Council on Medical Services: This resolution has been implemented by both the Council on Medical Services and the Council on Legislation. While a final resolution of the amendment to the statute has not been completed, the Council on Legislation has placed this matter on the FMA's legislative agenda. This matter will be addressed again during the 1987 legislative session when it is anticipated that the FMA will have an opportunity to devote more time to this issue.

The Council on Medical Services and the Committee on School Health have continued to remain active on this issue. The Committee on School Health has conducted a special meeting in Tampa that was confined to the pre-school physical issue. The meeting was attended by representatives of the Florida Osteopathic Medical Association, Florida Pediatric Society, Florida Academy of Family Physicians, Florida Association of County Health Officers and the Florida Conference of Medical Society Executives. As a result of this meeting, several recommendations were presented to the Board of Governors at its June 1986 meeting.

(See House of Delegates' Handbook, Board Report B)

RESOLUTION 85-24
Medical Licensure
Duval County Medical Society

RESOLVED, That the Florida Medical Association reaffirm its position to actively oppose any proposed legislation providing exception under the Medical Practice Act; and be it further

RESOLVED, That the Florida Medical Association inform all parties seeking exception to the Medical Practice Act of its position on this issue, and request those parties to cease their attempts to seek these exceptions.

This resolution was adopted by the House of Delegates and referred to the Board of Governors for implementation.

During the 1985 legislative session, FMA did oppose exemptions to the Medical Malpractice Act but was unsuccessful in defeating amendments to Chapter 458 allowing certain individuals preferential medical licensure treatment. These amendments were known as the "Mayo Clinic" amendments.

RESOLUTION 85-25
HMO Financial Responsibility
FMA Council on Hospital Medical Staffs

RESOLVED, That the Florida Medical Association seek passage of legislation to:

1. Require HMOs to meet their financial responsibility to physicians and hospitals when a patient is given emergency care in a hospital for that which is considered by the Emergency Room physician to be a bona fide emergency.

2. Require HMO reimbursement of non-participating physicians within a reasonable time period, i.e., within thirty (30) days after delivery of care.

This substitute resolution was adopted and referred to the Board of Governors for implementation.

RESOLVED, That the Florida Medical Association seek passage of legislation (and/or modification of legislation currently being considered) to require HMOs to meet their financial responsibility to patients, physicians, and hospitals in the circumstance when a patient is given emergency care in a hospital for that which is considered by the physician or physicians delivering such care to be a bona fide emergency, and the HMO does not arrange timely provisions of services, and the physician or hospital are unable to obtain timely authorization for such care; and be it further

RESOLVED, That legislation be immediately sought to require HMO reimbursement of non-participating physicians within a reasonable time period (i.e., within thirty (30) days after delivery of care).

The resolution was subsequently referred by the Board to the Council on Legislation and subsequent legislation during the 1985 legislative session was adopted to require HMO contracts to provide reimbursement of physicians who provide emergency care to HMO patients (Section 641.31, Florida Statutes).

RESOLUTION 85-26 (EMERGENCY RESOLUTION)
State Epidemiologists
Public Health Committee and the Preventive Medicine Society

RESOLVED, That the Florida Medical Association request and urge the Governor, the President of the Senate, the Speaker of the House and the Secretary of the Department of HRS to immediately establish and budget for a position of state epidemiologist and that recruitment for a qualified physician-epidemiologist licensed in the State of Florida be initiated immediately so that protection of the public's health against epidemic disease may be assured.

The resolution was adopted and referred to the Board of Governors for implementation.

The FMA assisted in ensuring that the 1985 Appropriations Bill contained a provision providing for the creation of a state epidemiologist with accompanying budget of approximately $85,000. Immediately after the House action, Luis M. Perez, M.D., President of the Florida Medical Association, contacted HRS Secretary David Pingree strongly endorsing the appointment of E. Charlton Prather, M.D., as state epidemiologist. Dr. Prather was appointed to the position effective October of 1985.



Yank D. Coble Jr., M.D., FMA Treasurer; John E. Thrasher, FMA General Counsel; and Guy T. Selander, M.D., FMA Speaker of the House.

Reference Committee III
Cap of 250 Delegates

This matter was referred to the Board of Governors for consideration.

The House of Delegates approved the recommendation of Reference Committee III that recommends the Board of Governors, through the Bylaws Committee, consider removing the cap of 250 delegates from county medical societies and, further, that consideration be given to establishing the ratio of 1 delegate per 40 members for county medical societies with no cap on the total number of county medical society delegates in the House. This matter was referred to the Bylaws Committee, and the Bylaws Committee has in its recommendations contained in a separate Board report submitted to the House of Delegates the recommendation that the cap of 250 delegates for county medical societies be removed.

Reference Committee III
Incompetent or Inadequate Doctor

The House of Delegates adopted the recommendations of Reference Committeee III on the Supplemental Report of the Judicial Council dealing with the incompetent or inadequate doctor and requested that the Board report back to the House with recommendations dealing with disciplinary matters in restructuring the FMA grievance process.

The Judicial Council has spent a considerable amount of time on this issue and has prepared a detailed report with recommendations (see annual report of Judicial Council). The Board considered the report at its meeting of June 27, 1986, and requested further review by the Judicial Council to insure continuation of a prominent role in the grievance process by county medical societies. The Board has considered a subsequent report and recommendations from the Judicial Council.

RECOMMENDATION NO. F-1

THAT THE HOUSE OF DELEGATES APPROVE AS AMENDED THE PROPOSED CHANGES REGARDING THE PROCEDURES FOLLOWED BY FMA COMPONENT COUNTY MEDICAL SOCIETIES AND THE FMA JUDICIAL COUNCIL IN HANDLING GRIEVANCES FILED AGAINST MEMBERS OF THE FMA (APPENDIX F1).

Nominations.

Judicial Council. In compliance with the FMA Bylaws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1986.

RECOMMENDATION NO. F-2

THAT THE HOUSE OF DELEGATES APPROVE THE NOMINATION OF MAURICE H. LAZLO, M.D., OF MIAMI, FOR ELECTION TO AN ADDITIONAL FIVE-YEAR TERM ON THE JUDICIAL COUNCIL AS THE REPRESENTATIVE FOR DISTRICT D.

Committee on Membership and Discipline. In compliance with the FMA Bylaws, the Board of Governors considered nominations for terms expiring in 1986 on the Committee on Membership and Discipline.

RECOMMENDATION NO. F-3

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING NOMINATIONS FOR ELECTION TO THE COMMITTEE ON MEMBERSHIP AND DISCIPLINE FOR THE TERMS INDICATED:

DISTRICT 1: LEALIS L. HALE JR., M.D. (90)
DISTRICT 2: JAMES K. CONN, M.D. (90)
DISTRICT 3: SAMUEL J. ALFORD JR., M.D. (90)
DISTRICT 4: H. FRANK FARMER, M.D. (90)
DISTRICT 5: VICTOR J. BILOTTA, M.D. (90)
DISTRICT 6: THOMAS D. BARTLEY, M.D. (90)
DISTRICT 7: J. ROBERT QUALEY, M.D. (90)
DISTRICT 8: DONALD G. NIKOLAUS, M.D. (90)
DISTRICT 9: ROSS G. OLSON, M.D. (90)
WALTER LANE, M.D. (90)
DISTRICT 10: BOB PEDDY, M.D. (90)
DISTRICT 11: JOHN B. ADAMSON, M.D. (90)
DISTRICT 12: FRED S. CARTER, M.D. (90)
DISTRICT 13: JOSEPH P. O'BRYAN, M.D. (90)
DISTRICT 14: E. JOAN BARICE, M.D. (90)
DISTRICT 15: PETER A. TOMASELLO, M.D. (90)
DISTRICT 16: BARBARA DRABKIN, M.D. (90)
DISTRICT 17: CHASON WM. HAYES, M.D. (90)
DISTRICT 18: SHELDON ZANE, M.D. (90)
DISTRICT 19: NORMAN L. GOTTLIEB, M.D. (90)

Distinguished Layman Award. The Board has selected the 1986 recipient of the Distinguished Layman Award. The appropriate citation along with the criteria is included in the Delegates' Notebook.

Medical Malpractice Award. The Board has selected the 1986 recipient of the Medical Malpractice Award. The appropriate citation along with the criteria is included in the Delegates' Notebook.

Indigent Care Study. The Board reviewed a report and recommendation from the Council on Medical Economics for a study to be carried out to quantify the magnitude or distribution of uncompensated care currently being provided by Florida physicians. The study is expected to determine the level of indigent outpatient care on a statewide basis in terms of dollar amounts and the number of patients. The study will further develop patient profiles, encounters and billing and collections associated with the indigent case load in the private sector.

The proposed study is felt to be essential to the passage of adequate and appropriate legislation dealing with Florida's indigent care problem.

The Board reaffirmed indigent care as a major legislative priority of the Association during the 1987 session and authorized expenditures of up to $25,000 to fund a study of indigent health care provided in physicians' offices throughout the state to be conducted by the University of Florida Center for Health Policy Research who conducted a similar study for inpatient care of indigents pursuant to the Health Care Access Act of 1984.

Optometry Drug Issue. The Board considered a request from the Florida Society of Ophthalmology for the FMA to assist in the lawsuit contesting the constitutionality of various portions of Chapter 463, Florida Statutes, relating to drug prescribing privileges for optometrists.

The Board reviewed legal opinions regarding this issue from the FMA's General Counsel and the Legal Counsel of the Florida Society of Ophthalmology as to the potential merits of such a legal challenge. The Board also reviewed the past efforts of the Association both in the legislature and in the courts to resolve this issue. It was noted that the FMA has expended approximately $70,000 in direct costs on the issue to date.

The Board authorized FMA participation in the lawsuit with a financial contribution not to exceed ten percent of the total legal costs and not to exceed $30,000 with such assistance to be provided on an as needed basis and subject to the availability of funds. The Board also directed that the FMA participation in the lawsuit be subject to the active involvement of the FMA's legal counsel in the review and development of the strategies of this litigation and that the Board of Governors be kept apprised on the progress of the suit.

National Drug Campaign. The Board of Governors discussed President Reagan's initiative for a campaign to address the serious drug problem in the United States.

RECOMMENDATION NO. F-4

THAT THE HOUSE OF DELEGATES EXPRESS THE ASSOCIATION'S FULL AND ACTIVE SUPPORT OF PRESIDENT REAGAN'S NATIONAL INITIATIVE TO ADDRESS THE GROWING DRUG PROBLEM IN THE UNITED STATES AND FURTHER THAT THE FMA WORK THROUGH AND IN COOPERATION WITH ITS COMPONENT COUNTY MEDICAL SOCIETIES, RECOGNIZED SPECIALTY GROUPS AND APPROPRIATE STATE AND LOCAL GOVERNMENT AGENCIES AND VOLUNTARY GROUPS TO DEVELOP COMPREHENSIVE PUBLIC EDUCATION PROGRAMS AND INITIATIVES TO ADDRESS THIS SERIOUS PROBLEM WHICH IS HAVING A DEVASTATING EFFECT ON THE HEALTH AND MORALITY OF THE AMERICAN PUBLIC AND FURTHER THAT THIS IMPORTANT PROGRAM BE GIVEN HIGH PRIORITY WITHIN THE FISCAL CONSTRAINTS OF THE ASSOCIATION AND THAT ALL POSSIBLE SOURCES OF FUNDING FOR EFFECTIVE IMPLEMENTATION BE EXPLORED.

Legal Activities

AIA Vs. Insurance Commissioner of the State of Florida, Florida Medical Association, Et Al. On Wednesday, July 2, 1986, the day after the law became effective, circuit court in Tallahassee to have the Tort Reform and Insurance Act of 1986 declared unconstitutional. The lawsuit alleges that the legislation embraces numerous subjects and subjects that are "improperly connected" and, therefore, is unconstitutional pursuant to Article 3, Section 6, of the Florida Constitution. Additionally, there are several other counts that relate directly to the insurance rate rollback and insurance regulation provisions of the law. In each of these sections, the plaintiffs are seeking to have the specific provision declared unconstitutional.

The Florida Medical Association was granted leave to intervene as a party defendant in the lawsuit and has been actively defending in the case. As of this writing, the court has entertained legal arguments and accepted briefs in respect to the alleged violation that the statute contains more than one subjects and matters improperly connected therewith. The remaining part of the lawsuit is now scheduled to be heard September 4 and 5, 1986. It is anticipated that the judge will rule in early October and that this matter will then be quickly appealed to the First District Court of Appeals in Tallahassee and subsequently on to the Supreme Court of Florida

Contingency Fee Schedule. On June 30, 1986, the Florida Supreme Court, in a 4 to 3 decision, issued an opinion that established for the first time in Florida a contingency fee schedule for attorneys in personal injury cases. The Florida Medical Association actively participated in oral arguments and in briefing in respect to the adoption of the contingency fee schedule and was the only non-legal organization to argue the case before the Supreme Court supporting the contingency fee schedule. The schedule adopted by the Supreme Court provides that any contingency fee which exceeds the following schedule will be clearly excessive: A) 25% of any recovery, regardless of the amount prior to filing suit; B) 33⅓% of any recovery up to $1 million from the time of the filing of an answer or the demand for appointment of arbitrators; C) 40% of any recovery up to $1 million through the trial of the case; D) 30% of any recovery between $1 million and $2 million; E) 20% of any recovery in excess of $2 million. The new restrictions went into effect on July 1, 1986, concurrent with the tort reform legislation passed in the 1986 legislative session.

In the majority opinion, the court noted that it had refused to limit attorney fees in 1977 because there was evidence of significant abuses of contingency fees It is interesting to note that the Florida Medical Association also participated in that case. The majority justices said that there was still no evidence of abuse but that the public and the legislature perceived that

there was. They also indicated that they had hoped lawyer advertising would result in competition which would reduce fees, but this had not happened.

In addition to the above-stated limits, there are other limitations that are more restrictive if the defendant admits liability at the time of filing an answer and requests only a trial on damages.

Subsequent to the court's opinion, the Florida Bar has requested a rehearing on several matters covered in the court opinion. The Florida Medical Association has filed a petition in response to the Florida Bar's request for rehearing and has opposed all but one of the issues raised by the Florida Bar.

Workers' Compensation Fee Schedule. The Florida Medical Association, for the second year in a row, successfully argued before the three-member panel for an increase in the workers' compensation fee schedule. The increase was opposed by Associated Industries. In 1985, the three-member panel granted a 4.2% increase, and the increase for 1986 represented a 3.1% increase in total pay out.

Pharmacy Rules — Administrative Hearing. The Board of Medical Examiners in January took up the proposed pharmacy rules that had been previously established by the formulary committee which was, in turn, established by legislation adopted in 1985. The law provided that the three boards would have the role of adopting rules to implement the statute which would allow pharmacists to prescribe certain limited drugs.

The FMA presented testimony that the rule, as submitted, was not in compliance with the statute adopted by the State Legislature. More specifically, the implementing statute requires that dispensing procedures be established by the committee for each drug in the formulary. Dispensing procedures as spelled out in the statute may include matters related to reception of the patient, description of his or her condition, patient interview, patient/physician referral, product selection and dispensing and use limitations. The FMA argued that the proposed rule is deficient in providing such procedures for each drug. The Board of Medical Examiners considered this argument and rejected the rule. This action delayed implementation of the rule and sent it back to the formulary committee for further work in respect to the Board of Medical Examiners' objections. Subsequent to this hearing, the formulary committee reconsidered the proposed rule and made the necessary changes suggested by the Board of Medical Examiners and raised by the Florida Medical Association to allow the rules to be implemented.

Rasmussen v. South Florida Blood Service, Inc. The Florida Medical Association, in conjunction with the Dade County Medical Association and the American Medical Association, filed a brief as amicus curiae in the case of Donald Rasmussen v. The South Florida Blood Service, Inc. This case is currently pending before the Supreme Court of the State of Florida.

In this case, the attorneys for Mr. Rasmussen sought records of blood donors who had given blood that was transfused to their client. The South Florida Blood Service refused to produce these records but was subsequently ordered to do so by circuit court. This order was appealed to the Third District Court of Appeals and that court ruled in favor of the position of the South Florida Blood Service which sought to protect the confidentiality of their records.

It is the position of the FMA in this case that, if donors' records are subject to inspection by lawyers on fishing expeditions, blood donor recruitment would become almost impossible. Also, a logical extension of a decision against The South Florida Blood Service could be to hold individuals liable for the adverse consequences of transfusions of their blood. Certainly, no one would voluntarily donate blood if the individual could be sued, with or without adequate grounds, by the recipient. Moreover, unless blood donors' records are held in the strictest of confidence, certain test results could be used to harass or discriminate against blood donors. For these reasons and others, the Florida Medical Associaiton has joined with the DCMA and the AMA to defend the confidentiality of blood donor records. This case has been briefed and argued before the Supreme Court of Florida and a decision from that court is pending.

Parikh v. Cunningham. Early in 1985, the Fifth District Court of Appeals handed down a decision in *Cunningham v. Parikh, M.D.*, in which the Court interpreted and held unconstitutional the Florida Medical Consent Law. FMA filed an *amicus curiae* brief in the Florida Supreme Court, contending that the District Court had misinterpreted the Medical Consent Law. In the meantime, FMA also sought to have the statute clarified legislatively to remove any ambiguity that might have existed. The 1985 Legislature did clarify the statute to ensure that where a physician advised a patient of the known risks of a procedure and the patient consents to the procedure, then the physician cannot be held liable when one of the known risks materializes. The Florida Supreme Court also finally ruled on the case in July of this year and reversed that portion of the DCA's opinion which had held the statute unconstitutional. The Supreme Court held "that the District Court reached an erroneous conclusion by misreading a crucial element of the statutory presumption."

White v. Schutze. Early is 1985, the FMA intervened as a party defendant in two cases in Marion County which sought to have declared unconstitutional portions of the medical examiner statute which directs that autopsies be performed when death results from certain specified causes and the cornea removal statute which authorizes medical examiners to, without consent of the next of kin, remove the cornea of those undergoing autopsies.

The trial court upheld the medical examiner statute but found the cornea removal statute to be unconstitutional. The case was appealed to the Supreme Court, where FMA supported the constitutionality of the cornea removal statute. A decision has not yet been rendered by the Supreme Court.

RESOLUTION 86A-1
Vice Speaker
Broward County Medical Association

Resolution 86A-1 was adopted.

RESOLUTION 86A-1

Vice Speaker

RESOLVED, That the Vice Speaker of the House of Delegates, Florida Medical Association, shall be made an Advisory Member of the Board of Governors.

RESOLUTION 86A-3
Unified Membership with the American Medical Association
Palm Beach County Medical Society

A Substitute Resolution 86A-3 was offered by Lee A. Fischer, M.D., Palm Beach County, which was adopted. The motion of the Reference Committee that Substitute Resolution 86A-3 be referred to the Board of Governors carried.

SUBSTITUTE RESOLUTION 86-3

Unified Membership with the American Medical Association

(Referred to Board of Governors)

RESOLVED, that the Florida Medical Association urge all physicians to join the American Medical Association, and that the Board of Governors study the advantages and disadvantages of unified AMA membership and report their findings and recommendations to the 1987 House of Delegates.

RESOLUTION 86A-4
Competition in Medicine
Palm Beach County Medical Society

Resolution 86A-4 was adopted

RESOLUTION 86A-4

Competition in Medicine

RESOLVED, That the Florida delegation to the American Medical Association introduce a resolution at the 1986 Interim Session of the AMA House of Delegates asking the AMA to serve as a clearing house for information and strategies that local physician groups can use to educate the public concerning the advantages and disadvantages of various forms of health care delivery; and be it further

RESOLVED, That the AMA publicize this service to the entire federation.

RESOLUTION 86A-6
FMA Membership as a Requirement for Licensure
Orange County Medical Society

Resolution 86A-6 was adopted.

RESOLUTION 86A-6

FMA Membership as a Requirement for Licensure

RESOLVED, That the FMA House of Delegates express its concern that there is a need for physicians to have adequate power for self-disciplining, and request that the Board of Governors conduct an appropriate study of the desirability of requesting that the state legislature make FMA membership a requirement for licensure with a report of the study and a recommendation by the Board of Governors to be submitted to the House of Delegates at the annual meeting in 1987.

RESOLUTION 86A-10
Commendation for FMA
Dade County Medical Association

Resolution 86A-10 was adopted.

RESOLUTION 86A-10

Commendation for FMA

RESOLVED, That the Board of Governors and the Council on Legislation of the Florida Medical Association be commended for outstanding achievements during the 1986 legislative session.

RESOLUTION 86A-11
County Medical Society Judicial Councils
Dade County Medical Association

The motion of the Reference Committee that Resolution 86A-11 be referred to the Board of Governors for review in conjunction with Recommendation No. F-1 carried.

RESOLUTION 86A-11

County Medical Society Judicial Councils

(Referred to Board of Governors)

Whereas, any efforts to increase activities which uphold and promote the high standards of the medical profession would be a benefit to the profession and the public; and

Whereas, such activities can be most comprehensive at the local level; and

Whereas, a coordinated statewide effort at upholding the standards of the profession would provide a valuable service to the citizens of Florida; therefore be it

RESOLVED, That the Florida Medical Association explore the formation of judicial councils at the county medical society level to implement under the auspices of the State Board of Medical Examiners an aggressive program to uphold and promote the highest standards of medical and professional conduct of physicians.

RESOLUTION 86A-12
Promoting Fee-for-Service Medicine
Dade County Medical Association

The Reference Committee noted that the subject of Resolution 86A-12 was the same as that contained in 85-1 and 85-10 included in Report F of the Board of Governors referrals to the House of Delegates.

The motion of the Reference Committee to not adopt Resolution 86A-12 was carried.

RESOLUTION 86A-13
Proceedings of the House of Delegates
Dade County Medical Association

Resolution 86A-13 was adopted.

RESOLUTION 86A-13

Proceedings of the House of Delegates

RESOLVED, That beginning with the 1987 Annual Meeting, the format of the proceedings for the House of Delegates as published in the *Journal of the Florida Medical Association* be revised to be consistent with that utilized by the American Medical Association.

RESOLUTION 86A-14
House of Delegates Referrals
Dade County Medical Association

Resolution 86A-14 was adopted.

RESOLUTION 86A-14

House of Delegates Referrals

RESOLVED, That beginning with the 1987 Annual Meeting, the Board of Governors ensure that information regarding the disposition of resolutions referred to it the previous year be distributed to each component county medical association, delegate and alternate delegate no later than sixty days prior to the opening session of the House of Delegates.

RESOLUTION 86A-17
Physically Challenged Physicians
Dade County Medical Association

The motion by the Reference Committee to refer Resolution 86A-17 to the Board of Governors carried.

RESOLUTION 86A-17

Physically Challenged Physicians

(Referred to Board of Governors)

Whereas, many physicians have significant physical disabilities, and as physicians age they may encounter increasing physical disability; and

Whereas, there is a need to address such issues as wheelchair accessibility, financial assistance, disability insurance, family relationships, developing new skills and exploring community resources on behalf of physically challenged physicians; and

Whereas, the Los Angeles County Medical Association has developed a model for a successful program for physically challenged physicians; therefore be it

RESOLVED, That the Florida Medical Association develop a program for physically challenged physicians.

RESOLUTION 86A-32
Fiscal Note to Resolutions
Duval County Medical Society

The motion of the Reference Committee that Resolution 86A-32 be amended by adding the words "of the Florida Medical Association" on line 10 after the word "Delegates" carried.

RESOLUTION 86A-32

Fiscal Note to Resolutions

RESOLVED, That all future proposals and recommendations from the Board of Governors, Councils and Committees, and Resolutions presented to the House of Delegates of the Florida Medical Association include a fiscal note.

RESOLUTION 86A-36
Investigation of Self Insurance Trusts
Dade County Medical Association

The motion of the Reference Committee to refer Resolution 86A-36 to the Board of Governors carried.

RESOLUTION 86A-36

Investigation of Self Insurance Trusts

(Referred to Board of Governors)

Whereas, many physicians and other professionals maintain professional liability insurance through self insurance trusts; and

Whereas, such trusts obligate its members to assessments when operating shortfalls occur; and

Whereas, several hundred physicians have recently been assessed dramatic sums by the Caduceus Self Insurance Fund for activities of 1981-84; and

Whereas, the disastrous situation faced by these physicians may not be an isolated case; therefore be it

RESOLVED, That the Florida Medical Association expresses its concern over the widespread use of assessable self insurance trusts as a means of physicians maintaining professional liability insurance; and be it further

RESOLVED, That the Florida Medical Association request that the Florida Department of Insurance conduct a formal investigation of all self insurance trusts operating in Florida to ensure that physicians and other professionals will not fall victim to disastrous consequences.

RESOLUTION 86A-37
Relocation of FMA Headquarters
Dade County Medical Association

The Reference Committee received a request from the Dade County Medical Association to withdraw Resolution 86A-37. The motion of the Reference Committee to not adopt Resolution 86-37 carried.

RESOLUTION 86A-40
1986 Constitutional Initiatives
Dade County Medical Association

The motion of the Reference Committee to refer Resolution 86A-40 to the Board of Governors carried.

RESOLUTION 86A-40

1988 Constitutional Initiatives
Dade County Medical Association

Whereas, the professional liability insurance crisis continues to face Floridians; and

Whereas, recently enacted State legislation may not withstand constitutional challenges; and

Whereas, current state statutes governing this issue remain inadequate to resolve the professional liability crisis; therefore be it

RESOLVED, That the Florida Medical Association (preferably in concert with the Florida Coalition for Liability Reform) immediately initiate all activity necessary to achieve numerous constitutional initiatives in 1988 regarding professional liability; and be it further

RESOLVED, That such initiatives be developed to:

1) Place further limits on awards for general damages,
2) Abolish the Doctrine of Joint and Several Liability,
3) Establish a contingency patient compensation scale, and
4) Institute the mandatory use of medical mediation panels.

The Chairman thanked each member of the Reference Committee: Kevin M. McAuliffe, M.D.; Harold L. Ishler, M.D.; Calvin W. Martin, M.D.; Robert R. Eastridge, M.D.; and Richard J. Bagby, M.D., and he also thanked the AMA Delegate Advisor: Charles J. Kahn, M.D.; Mr. Donald C. Jones, Executive Vice President; Ms. Lynn Mobarak and Ms. Linda Flowers, Recorders; and FMA staff members for their support of the Committee and the many members of the Association who attended their meeting and presented testimony.

The motion of the Reference Committee that the report of Reference Committee No. III, Finance and Administration, be adopted as amended carried.

The Vice Speaker, Dr. Eberly, opened the floor for nominations of officers and AMA Delegates and Alternates.

Speaker of the House
Vice Speaker
Secretary
Treasurer
District A, Board of Governors
AMA Delegate Seat #2
AMA Alternate Seat #2
AMA Delegate Seat #3
AMA Alternate Seat #3
AMA Delegate Seat #5
AMA Delegate Seat #10
AMA Alternate Seat #10
AMA Delegate Seat #11
AMA Alternate Seat #11

The Speaker had previously received a motion from Dr. Charles P. Hayes Jr., on behalf of the Duval County Delegation, to elect by acclamation candidates for Speaker of the House, Vice Speaker, Secretary, Treasurer, District A of the Board of Governors, AMA Delegate Seats 2, 3, 5, 10, 11 and Alternate Delegate Seats 2, 3, 10, 11. The motion was carried and the following candidates were elected.

Speaker of the House — Guy T. Selander, M.D.
Vice Speaker — Arthur L. Eberly Jr., M.D.
Secretary — Henry M. Yonge, M.D.
Treasurer — Yank D. Coble Jr., M.D.
District A of the Board of Governors — Gerold L. Schiebler, M.D.
AMA Delegate Seat #2 — Joseph T. Ostroski, M.D.
AMA Alternate Seat #2 — James B. Perry, M.D.
AMA Delegate Seat #3 — Charles K. Donegan, M.D.
AMA Alternate Seat #3 — Lee A. Fischer, M.D.
AMA Delegate Seat #5 — Richard G. Connar, M.D.
AMA Delegate Seat #10 — Luis M. Perez, M.D.
AMA Alternate Seat #10 — Arthur L. Eberly, M.D.
AMA Delegate Seat #11 — Sanford A. Mullen, M.D.
AMA Alternate Seat #11 — Dick L. Van Eldik, M.D.

The new terms for Delegate Seats 2, 3, 5, 10, 11 and Alternate Delegate Seats 2, 3, 10, 11 are for two years beginning January 1, 1987 and expiring December 31, 1988.

Nominations

President-Elect

The Vice Speaker opened the floor for nominations for the office of President-Elect. Dr. Richard W. Snodgrass of Volusia County nominated Dr. James G. White of Volusia County. The nomination was seconded by Dr. Gerold L. Schiebler of Alachua County; Dr. Bruce W. Weissman of Dade County; Dr. Richard S. Hodes of Hillsborough County; Dr. Calvin W. Martin of DeSoto-Hardee-Glades; Dr. Dick L. Van Eldik of Palm Beach County; Dr. Eric F. Geiger of Escambia County; Dr. Charles P. Hayes Jr., of Duval County; and Dr. John M. Hamilton of Pinellas County.

Vice President

The floor was opened for nominations for the office of Vice President. Dr. Bruce P. Smith of Pinellas County nominated Dr. Kay K. Hanley of Pinellas County. The nomination was seconded by Dr. Rufus K. Broadaway of Dade County; Dr. Charles P. Hayes Jr., of Duval County; Dr. Lee A. Fischer of Palm Beach; Dr. Gerold L. Stoker of Hillsborough County; and Dr. F. Lee Howington of Lee County.

Resident Physician of the Board of Governors

The floor was opened for nominations for a resident physician of the Board of Governors for a two-year term expiring in 1988. Dr. Thomas H. Moore Jr., of Alachua County nominated Dr. James G. Dolan of Alachua. The nomination was seconded by Dr. Kay K. Hanley of Pinellas County and Dr. Alvin E. Smith of Volusia County.

Dr. T. Byron Thames of Orange County nominated Dr. Keith E. McManus. The nomination was seconded by Dr. Joseph T. Ostroski of Dade County and Dr. Lee A. Fischer of Palm Beach.

AMA Alternate Seat #5

Dr. Richard L. Glatzer of Dade County nominated Dr. Harold G. Norman of Dade County. The nomination was seconded by Dr. Jerry D. Moore of Broward County; Dr. George W. Metcalf of Dade; Dr. V.A. Marks of Palm Beach; Dr. John S. Bruno, Florida Society of Plastic and Reconstructive Surgeons; and Dr. Mayard F. Taylor of Pasco County.

Dr. Bruce P. Smith nominated Dr. Donald G. Nikolaus, M.D.. The nomination was seconded by Dr. Thomas D. Bartley of Alachua County; Dr. Charles B. McIntosh of Duval County; and Dr. James F. Richards Jr., of Orange County.

AMA Delegate Seat #9

Dr. Bruce W. Weissman of Dade County nominated Dr. Charles A. Dunn of Dade County. The nomination was seconded by Dr. George P. Messenger of Broward County; Dr. Marc D. Kaye of Duval County; Dr. Herbert E. Brooks of Panhandle; and Dr. Donald B. Twiggs of Florida Academy of Family Physicians.

Dr. William E. Hale of Pinellas County nominated Dr. Kay K. Hanley of Pinellas County. The nomination was seconded by Dr. Gaston J. Acosta-Rua of Duval County; Dr. E. Joan Barice of Palm Beach

County; Dr. Charles J. Kahn of Escambia County; Dr. Alvin E. Smith of Volusia County; Dr. Glenn S. Hooper of Hillsborough County; and Dr. Theodore W. Hahn of Broward County.

AMA Alternate Seat #9

Dr. Peter A. Tomasello of Broward County nominated Dr. Theodore W. Hahn of Broward County. The nomination was seconded by Dr. Virgil A. Ponzoli Jr., of Collier County; Dr. Bruce W. Weissman of Dade County; Dr. William J. Romanos Jr., of Palm Beach County; Dr. Alvin E. Smith of Volusia County; John W. Glotfelty of Polk County; and Dr. Kenneth C. Keihl of Sarasota County.

Judicial Council

The Vice Speaker referred the House to the Report of the Board of Governors (Report F) in which the Board had nominated Maurice H. Laszlo, M.D., of North Miami Beach, to a five-year term which would expire in 1991, on the Judicial Council as a representative at large.

Committee on Membership and Discipline

The Vice Speaker referred the House to the nominations for elections to the Committee on Membership and Discipline as submitted by the Board of Governors in its Report F of the Board of Governors and advised the House that he would entertain any additional nominations from the floor. The Vice Speaker noted that all nominees were unopposed except for District 9. The Vice Speaker announced the names of the nominees for each district:

District 1:	Lealis L. Hale Jr., M.D. (90)
District 2:	James K. Conn, M.D. (90)
District 3:	Samuel J. Alford Jr., M.D. (90)
District 4:	H. Frank Farmer, M.D. (90)
District 5:	Victor J. Bilotta, M.D. (90)
District 6:	Thomas D. Bartley, M.D. (90)
District 7:	J. Robert Qualey, M.D. (90)
District 8:	Donald G. Nikolaus, M.D. (90)
District 9:	Ross G. Olson, M.D (90)
	Walter Lane, M.D. (90)
District 10:	Bob Peddy, M.D. (90)
District 11:	John B. Adamson, M.D. (90)
District 12:	Fred S. Carter, M.D. (90)
District 13:	Joseph P. O'Bryan, M.D. (90)
District 14:	E. Joan Barice, M.D. (90)
District 15:	Peter A. Tomasello, M.D. (90)
District 16:	Barbara Drabkin, M.D. (90)
District 17:	Chason Wm. Hayes, M.D. (90)
District 18:	Sheldon Zane, M.D. (90)
District 19:	Norman L. Gottlieb, M.D. (90)

The Speaker then announced that the President's Inauguration would be held at 5:30 in the Regency West.

The Meeting of the Second House of Delegates recessed at 4:15 p.m. to reconvene on Sunday, September 21, 1986 at 8:30 a.m.

President's Inauguration and Reception













The first President's Inauguration was held at the 1986 Annual Meeting. (1) Drs. Maria and Luis Perez (2) Dr. and Mrs. James B. Perry (3) Ms. Wanda McWaters and Mr. Donald C. Jones give instructions to the participants of the President's Inauguration (4) The participants listen for their parts (5) Drs. Edward Annis and Luis Perez (6) Drs. Louis C. Murray, James G. White, and A. Frederick A. Schild.

























(7) Drs. Sanford A. Mullen and Edward Annis (8) Mrs. V.A. (Susan) Marks and Mrs. Milton (Jo) Tignor (9) Drs. Yank D. Coble, Charles P. Hayes, and Henry M. Yonge (10) Mr. Donald C. Jones and Dr. Luis M. Perez (11) Drs. T. Byron Thames, Guy T. Selander and Joseph C. Von Thron (12) Drs. O. William Davenport and Edward Annis (13) Miss Jane A. Daniel and Dr. Edward Annis (14) The stage with participants consisting of the FMA Officers and Board of Governors, Past Presidents, Auxiliary Immediate Past President and President, County Medical Society Presidents and other distinguished guests (15) 21st Century Strings (16) Drs. Luis M. Perez; Enrique Huertas, President, Cuban Medical Association in Exile; Frank C. Coleman, and James B. Perry. Dr. Huertas made a presentation in honor of Dr. Perez (17) At the President's Reception, Drs. Luis and Maria Perez, Mrs. James B. (Peg) Perry and Dr. James B. Perry (18) Dr. and Mrs. Joseph C. Von Thron.

Change of Leadership













The installation of the new President was held during the President's Inauguration. (1) Dr. Luis M. Perez, Immediate Past President, addresses the audience. (2) Dr. James B. Perry addresses the audience with his first speech as President. (3) Dr. Maria Perez is presented the Presidential Portrait of her husband Dr. Luis Perez by Dr. Frank C. Coleman. (4) Dr. Frank C. Coleman swears in Dr. James B. Perry. (5) Dr. Luis M. Perez presents Dr. James B. Perry with the Presidential Medallion. (6) Dr. Perry displays the President's Plaque and Gavel while Dr. Perez looks on.

Third House of Delegates

The third meeting of the House of Delegates convened at 8:40 a.m. on Sunday, September 21, 1986, in the Regency East/South Room of the Diplomat Hotel, Hollywood, Florida, with Guy T. Selander, M.D., Speaker of the House, presiding.

Dr. E. Joan Barice of the Credentials Commitee reported that 231 Delegates were registered, representing 29 component county societies, which constitutes a quorum, and moved that the Delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Mark V. Barrow, M.D.; Thomas D. Bartley, M.D.; Robert K. Casey, M.D.; James O. Dailey, M.D.; J. Lee Dockery, M.D.; Thomas H. Moore Jr., M.D. (Absent — Mr. Manuel R. Padron, Student Delegate)

BAY — James T. Cook III, M.D.; Ted R. Wilson, M.D. (Absent — Stephen J. Toner, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D.; Richard I. Barr, M.D.; Glenn E. Bryan, M.D.; Onofre P. Carrillo, M.D.; Antonio U. Catasus, M.D.; Robert C. Ufferman, M.D.; Joseph C. Von Thron, M.D.

BROWARD — Leroy G. Appell, M.D.; Anna M. Blenke, M.D.; Bruce B. Burgess, M.D.; Andre S. Capi, M.D.; George T. Edwards, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Theodore W. Hahn, M.D.; James A. Jordan, M.D.; Rolando Jorge, M.D.; Linda J. Kaplan, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Arthur E. Palamara, M.D.; Ernest G. Sayfie, M.D.; Peter A. Tomasello, M.D.; Dana V. Wallace, M.D.; Juan S. A. Wester, M.D.; Alan J. Yesner, M.D. (Absent — Phillip A. Caruso, M.D.; Ernest Constantino, M.D.; George J. Crane, M.D.; David A. D'Alessandro, M.D.; William C. Hartley, M.D.; George P. Messenger, M.D.; Richard D. Shafron, M.D.; Marvin L. Stein, M.D.; Nelson R. Zide, M.D.)

CAPITAL — Robert P. Johnson, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — Samuel R. Miller, M.D. (Absent — W. Randall Jenkins, M.D.)

CLAY — Charles E. Phillips, M.D.; Darrel W. Wyatt, M.D.

COLLIER — Charles S. Eytel, M.D.; Donald W. Ketterhagen, M.D.; Virgil A. Ponzoli Jr., M.D.

COLUMBIA — Nanjunda Swamy, M.D.

DADE — Edward R. Annis, M.D.; Allen Baumal, M.D.; Jerome Benson, M.D.; Pedro P. Bosch, M.D.; Robert E. Boyett, M.D.; James W. Bridges, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Harlan S. Chiron, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Barbara S. Drabkin, M.D.; Charles A. Dunn, M.D.; Jerry E. Ennis, M.D.; Edward J. Feller, M.D.; Miguel Figueroa, M.D.; Simon J.H. Frank, M.D.; Humberto L. Fontana, M.D.; N. Ra¹ph Frankel, M.D.; Richard L. Glatzer, M.D.; Paul A. Gluck, M.D.; James J. Hutson, M.D.; Donald E. Johnson, M.D.; Norman M. Kenyon, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda A. Marraccini, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto, M.D.; William I. Roth, M.D.; Bruce S. Saltzman, M.D.: A. Frederick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C.S. Skinner, M.D.; Douglas Slavin, M.D.; Osvaldo D. Valdes, M.D.: Harold H. Weiner, M.D.; Daniel M. Weingrad, M.D.; Bruce W. Weissman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D. (Absent — Bernard J. Fogel, M.D.; Enrique Gomez, M.D.; Pedro Romas, M.D.; Oscar Sandoval, M.D.; Marvin B. Slotkin, M.D.; Leon Suissa, M.D.; Leo Whitman, M.D.; Mr. George David Markovich, Student Delegate)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Gaston J. Acosta-Rua, M.D.; Merrill Anderson, M.D.; Clyde M. Collins, M.D.; Patricia C. Cowdery, M.D.; Wilbert L. Dawkins, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; John F. Lovejoy, M.D.; Charles B. McIntosh, M.D.; Kevin M. McAuliffe, M.D.; Sanford A. Mullen, M.D.; David H. Ogburn, M.D.; Charles R. Snyder, M.D.; H. Warner Webb, M.D.; C. Davis Whelchel III, M.D. (Absent — Joseph D. Foley, M.D.; Marc D. Kaye, M.D.; Kurt W. Mori, M.D.; W. D. Walklett, M.D.)

ESCAMBIA — Paul T. Baroco, M.D.; Eric F. Geiger, M.D.; Everett S. Havard, M.D.; Charles J. Kahn, M.D.; James M. Potter, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson, M.D.

FLAGLER — (Absent — John M. Canakaris, M.D.)

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew, M.D.

HIGHLANDS — (Absent — Eustus Nelson, M.D.; Richard G. Spindler, M.D.)

HILLSBOROUGH — Miguel R. Alonso, M.D.: Pierre Bouis Jr., M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Waite S. Kirkconnell, M.D.; Victor H. Knight Jr., M.D.; Ralph E. Rydell, M.D.; Gerald L. Stoker, M.D.; James A. Winslow Jr., M.D. (Absent — Lawrence Cohen, M.D.; Mutaz Habal, M.D.; Thomas E. McKell, M.D.; Robert E. McCammon, M.D.; Ronald L. Seeley, M.D.; Ferdinando Vizzi, M.D.; Chris Centeno, Student Delegate)

INDIAN RIVER — Kip Kelso, M.D.; John W. McDonald, M.D.; Michael B. Zimmer, M.D.

LAKE — John L. Geeslin, M.D.; Joseph E. Holland, M.D. (Absent — William H. Shutze, M.D.)

LEE — William R. Bess Jr., M.D.; Robert J. Brueck, M.D.; Larry P. Garrett, M.D.; F. Lee Howington, M.D.; T. T. Knight, M.D.; Marcus M. Moore, M.D.; Douglas A. Newland, M.D.;

MADISON — M. Linda Dulay, M.D.

MANATEE — Thomas R. Busard, M.D.; Gary L. Dunlap, M.D.; Julian Giraldo, M.D.; George R. McSwain, M.D. (Absent — Gerald G. Whitt, M.D.)

MARION — Henry L. Harrell Jr., M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D. (Absent — James M. Hayes, M.D.)

MONROE — (Absent — Ronald H. Chase, M.D.)

NASSAU — (Absent — Cecil B. Brewton, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; William W. Thompson, M.D.

ORANGE — Richard J. Bagby, M.D.; Henry J. Baskin, M.D.; Clarence H. Brown, M.D.; Wayne L. Godbold, M.D.; Jay M. Hughes, M.D.; Angelo Massaro, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Calvin R. Peters, M.D.; Wallace M. Philips Jr., M.D.; James F. Richards, M.D.; Philip N. Styne, M.D.; Thomas B. Thames, M.D.; Cecil B. Wilson, M.D. (Absent — Manuel J. Coto, M.D.; David L. Mackey, M.D.)

OSCEOLA — Alonzo J. Logan, M.D.; Gilberto Perez, M.D.

PALM BEACH — Roberto Acosta, M.D.; Joe A. Baker, M.D.; E. Joan Barice, M.D.; Richard C. Cavanagh, M.D.; McKinley Cheshire, M.D.; Tommy M. Coffman, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; V. A. Marks, M.D.; R. Benjamin Moore, M.D.; Gilbert R. Panzer, M.D.; William J. Romanos Jr., M.D.: Anthony L. Thebaut, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D. (Absent — J. Russell Forlaw, M.D.; Myron M. Persoff, M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Maynard F. Taylor, M.D. (Absent — Marc S. Freedman, M.D.; Carl W. Graves, M.D.)

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony P. Garritano, M.D.; William E. Hale, M.D.; John M. Hamilton, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris Levine, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Jack N. Rothman, M.D.; Bruce P. Smith, M.D.; James L. West Jr., M.D. (Absent — William H. Schmid, M.D.)

POLK — Annette C. Barnes, M.D.; Francis D. Drake, M.D.; Richard M. Garcia, M.D.; John W. Glotfelty, M.D.; David T. Jones, M.D.; Thomas E. McMicken, M.D.; Robert B Peddy, M.D.; Dale L. Taylor, M.D. (Absent — Henry M. Haire, M.D.)

PUTNAM — (Absent — Roy E. Campbell, M.D.)

ST. LUCIE-OKEECHOBEE — Manuel Garcia, M.D.; Khalil Cassimally, M.D. (Absent — David L. Fromang, M.D.)

SANTA ROSA — David B. Young, M.D.

SARASOTA — William E. Bush, M.D.; John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Charles R. Mathews, M.D.; Franklin H. Pfeiffenberger, M.D.; Karl R. Rolls, M.D.: Ernest C. Smith Jr., M.D.; Phyllis A. Stephenson, M.D.; David L. Thomas, M.D.

SEMINOLE — Humberto A. Dominguez, M.D.; Maria P. Perez, M.D. (Absent — Orlando Garcia-Piedra, M.D.)

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Andrew C. Bass, M.D.)

TAYLOR — (Absent — John H. Parker, M.D.)

VOLUSIA — H. Frank Farmer Jr., M.D.; Richard Huster, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.; H.S.B. Treloar, M.D.

WALTON — Absent

WASHINGTON — Absent

SPEAKER OF HOUSE — Guy T. Selander, M.D.

VICE SPEAKER — Arthur L. Eberly, M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

SPECIALTY GROUP DELEGATES

ANESTHESIOLOGISTS, FLA. SOC. OF — Jimmie D. Moore, M.D

DERMATOLOGY, FLA. SOC. OF — Clifford Lober, M.D.

FAMILY PHYSICIANS, FLA. ACADEMY OF — Donald Twiggs, M.D.

PATHOLOGISTS, FLA. SOC. OF — Jerry L. Harris, M.D.

PEDIATRIC SURGEONS, FLA. ASSN. OF — Malvin Weinberger, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEONS, FLA. SOC. OF — John S. Bruno, M.D.

PREVENTIVE MEDICINE, FLA. SOC. FOR — Donald S. Kwalick, M.D.

PSYCHIATRIC ASSN., CO. OF FLA. DIST. BRANCHES OF THE AMERICAN — George W. Metcalf, M.D.

SURGEONS, FLA. ASSN. OF GENERAL — R. Bradford Pyle, M.D.

SPECIALTY GROUPS WITH NO DELEGATE REPRESENTATION AT THIRD HOUSE

Allergy and Immunology Soc., Fla.
Chest Physicians, Amer. Coll. of Fla. Chapter
Colon and Rectal Surgeons, Fla. Soc. of
Emergency Physicians, Am. Coll. of Fla. Chap.
Endocrine Society, Fla.
Gastroenterologic Soc., Fla.
Internal Medicine, Fla. Soc. of
Neonatal Perinatologists, Fla. Soc. of
Nephrology, Fla. Soc. of
Neurology, Fla. Soc. of
Neruosurgical Society Fla.
Nuclear Physicians, Fla. Assn. of
Obstetric & Gynecologic Soc. Fla.
Occupational Medical Assn., Fla.
Oncology, Fla. Soc. of Clinical
Ophthalmology, Fla. Soc. of
Orthopedic Society, Fla.
Otolaryngology, Head & Neck Sur., Fla. Soc. of
Pediatric Cardiologists, Fla. Assn. of
Pediatric Soc., Fla. and Pediatrics, American Academy, Fla. Chapter
Physician Medicine and Rehab., Fla. Soc. of
Physicians, American College of, Fla. Region
Radiological Society Fla.
Rheumatology, Fla. Soc. of
Surgeons, Amer. College of Fla. Chapter
Surgeons, International College of, Fla. State Surgical Division
Thoracic and Cardiovascular Surgeons, Fla. Soc. of
Thoracic Society, Fla.
Urological Society, Fla.

The Speaker gave special thanks for an excellent meeting and scientific program to Dr. Pierre J. Bouis Jr.; Dr. Robert C. Fore; Ms. Wanda McWaters; and Mrs. Dawn Gerik. The Speaker also thanked the entire FMA staff headed by Mr. Donald C. Jones for managing the meeting in a smooth manner.

Dr. Selander recognized Dr. John O. Brown, President of the National Medical Association.

Annual Me Highlights



(1) Annual Health Run for Fun (2) FMA Staff Marcia Protheroe and Cindy Curry (3) Dr. William H. Mathews, Louise Rader, former JFMA Managing Editor, and Mrs. Mathews (4) FMA House of Delegates (5) Speaker of the House Guy T. Selander, M.D. and Vice Speaker Arthur L. Eberly Jr., M.D. (6) George David Markovich, winner of the Health Run (7) Treasurer Yank D. Coble Jr., M.D. (8) Drs. Rufus K. Broadaway and Edward W. Annis (9) Dr. and Mrs. J. Lee Dockery.

eting



(10) Dr. Fred Carter finishes the Health Run (11) Dr. Henry M. Yonge and Robert W. Seligson, FMA Director of Medical Economics (12) Dr. and Mrs. Charles B. McIntosh (13) Dr. Charles P. Hayes Jr., Dr. Samuel M. Day and Mrs. Hayes (14) FMA Staff Member Saundra Law hands Dr. James Perry his finishing number (15) Dr. Rufus Broadaway and AMA Dr. President John J. Coury Jr. (16) Dr. Louis C. Murray (17) Dr. Joseph T. Ostroski and Dr. Charles K. Donegan.

Report of Reference Committee No. II Public Policy

Dr. Selander called the Chairman and members of Reference Committee No. II, Public Policy, to present their report.

Dr. William J. Romanos Jr., Chairman, and his Committee came forward to present the Report of Reference Committee No. II, Public Policy.

Report of the Council on Medical Services

The motion of the Reference Committee that the report of the Council on Medical Services be adopted as printed in the handbook carried.

Council on Medical Services
Joseph T. Ostroski, M.D., Chairman

Since the 1985 Annual Meeting of the Florida Medical Association, the Council on Medical Services and its six component committees have been involved with a wide range of issues, both legislative and non-legislative, affecting both Florida's very young and very old and all ages in between. To accomplish its work, the Council and its subordinate committees met formally a total of 20 times during the year.

The Council itself met three times to consider and to act upon reports and recommendations handed up by the component committees. These meetings were conducted in Tallahassee on September 15, 1985, and January 5, 1986, and in Tampa on June 6, 1986. Committee and Council recommendations have been transmitted in timely fashion to the Council on Legislation, the Executive Committee and the Board of Governors.

A summary of the more important activities in which the Council has been involved for the past year and a half is presented below under appropriate committee and other headings.

Correctional Health Care

The Chairman of the Council on Medical Services led a team of FMA physicians and staff on two visits to prison facilities in Florida for the purpose of reviewing and making recommendations with regard to health care services and facilities for inmates. The first on-site inspection, requested by Gov. Bob Graham, took place at the Florida Department of Corrections' Reception and Medical Center at Lake Butler on October 1, 1985. The second inspection occurred on December 19, 1985, at the Broward County Jail in Fort Lauderdale at the request of the Broward County Sheriff's Department.

Prison health services at both correctional facilities are provided under contract with private concerns. After each inspection, a detailed written report on the quality and availability of care was submitted to the appropriate authorities.

Legislation

1985-86 was an extremely active year in the legislative arena for the Council. Some of the major issues in which the Council was interested included trauma care, sunset of several allied health profession practice acts, reorganization of the Department of Health and Rehabilitative Services, indigent health care, drug dispensing authority for public health nurses, and funding for medical education in geriatrics, all of which will be addressed in the annual reports of the Council on Legislation and the Board of Governors and therefore require no elaboration in this report.

Health Manpower Shortage Areas

In accordance with procedures adopted by the House of Delegates in 1985 (Board of Governors Recommendation No. B-1), the Council has continued to serve as the FMA conduit between the federal Department of Health and Human Services and the county medical societies regarding health manpower shortage area designations. Under these procedures, HHS forwards all correspondence regarding these designations through the Council, and the county medical societies forward their responses to HHS through the Council. Only in a very few cases have counties elected to challenge or otherwise comment on these designations.

Within the context of this program, the Council participated in the 1985 Annual Review of Primary Care Health Manpower Shortage Areas conducted by HHS. Only the Orange County Medical Society filed a detailed response.

Inasmuch as Recommendation No. B-1, referred to above, assigned responsibility for health manpower shortage area review to the Committee on Health Manpower and in view of the fact that that committee no longer exists, the Council has recommended to the Board of Governors that the function be reassigned to the Committee on Public Health.

Committee on Aging

The Committee on Aging has been active in a number of areas under the able leadership of Chairman Eric A. Pfeiffer, M.D., of Tampa.

For the second consecutive year, the Committee will sponsor a Symposium on the Process of Aging at the 1986 FMA Annual Meeting. This will be presented on Thursday, September 18, with the co-sponsorship of the Florida Academy of Family Physicians and the Florida Medical Association Auxiliary.

"Health Notes for Older Adults," a camera-ready newspaper column, continues to be distributed on a monthly basis to Florida newspapers and to other publications intended primarily for older persons.

A Spanish language version of "Medi-File" has been produced and both Spanish and English editions are still available for Florida

physicians who wish to acquire them for their patients. "Medi-Filc" is a billfold-size card on which older patients can record pertinent information about their prescription drugs and carry it on their persons for use in an emergency. Demand for "Medi-File" has slackened considerably but its availability will be republicized in FMA publications.

The Committee continues its interest in and support for Florida's Alzheimer's Disease Program which the Legislature established with the support of the FMA in 1985. Dr. Pfeiffer was one of three physicians appointed to the Alzheimer's Disease Advisory Council established by the act.

The Committee is interested in achieving additional state funding for medical education in geriatrics. Gov. Bob Graham's proposed state budget contained $400,000 for funding faculty positions at the three medical schools, but that item apparently was not included in the budget that was considered by the Legislature.

The Committee and Council have proposed that two members of the Legislature be appointed as advisory members of the Committee during 1986-87, and a recommendation to this effect has been forwarded to the Board of Governors.

Committee on Emergency Medical Services

The Committee on Emergency Medical Services had a change in chairmen this year when Chairman Daniel E. Lucas, M.D., left the state. There was no interruption in the Committee's activities, however, since an experienced Committee member, H. Quillian Jones Jr., M.D., was immediately appointed to take his place.

The Committee's primary project for the past year has been the enactment of trauma center legislation. At the outset of the 1986 legislative session, prospects for enactment of a trauma bill appeared very good but certain unanticipated events dimmed the picture considerably. On the final day of the regular session, the issue was killed when the Speaker of the House of Representatives blocked it on the ground that he was opposed to any new taxes to fund legislation. The trauma bill included a provision that motor vehicle registration fees be raised by 10¢.

The Council and Committee will regroup and continue its pursuit of an effective and meaningful trauma act for the benefit of all Floridians and the hundreds of thousands of others who visit Florida each year.

Committee on Voluntary Health Agencies and Allied Health Professions

This Committee worked through its first year under the capable leadership of William W. Thompson, M.D. The Committee focused its activity on allied health professions, particularly the allied health practice acts that are due to sunset under Florida law this year.

Existing practice acts for nursing, physical therapy, pharmacy, optometry and others were reviewed and anticipated changes sought by these allied health professions were considered and evaluated. Several meetings were held with representatives of the professions to discuss their practice act goals and related matters.

Re-enactment practice acts will be summarized and discussed in other reports to the House of Delegates.

With most practice act sunsets now behind it, the Committee will concentrate in the coming year on rebuilding relationships with the voluntary health agencies.

Committee on Public Health

Legislative issues have been of extreme importance to the Committee on Public Health which has operated under the leadership of Robert D. May, M.D. Chief among these issues are reorganization of the Department of Health and Rehabilitative Services, indigent health care and authority of public health nurses to dispense medications to public health unit clients.

At its meeting on May 4, 1985, the Committee adopted a resolution calling on the Governor and the Legislature, which was then in session, to establish and budget for a position of state epidemiologist. Later that day, the resolution was introduced in the FMA House of Delegates as an emergency. It was adopted and immediately communicated to state officials. The position was established, funded and eventually filled. The Committee was credited with playing a significant role in this accomplishment.

Among other issues in which the Committee has been interested are the HRS Diabetic Retinopathy Project, Acquired Immune Deficiency Syndrome (AIDS) and medical malpractice protection for private physicians who render care on contract to public health clients. At the present time, the Committee is looking into ways it can assist the Boy Scout and Girl Scout organizations in Florida in their public health merit badge and related programs.

Committee on School Health

Several long-standing issues have continued to command the attention of the Committee on School Health which has been chaired by State Rep. Bernard Kimmel, M.D.

The Committee called a special meeting for June 22 to discuss the problem of school entry examinations. Joining in the discussions were the Florida Academy of Family Physicians, the Florida Pediatric Society, the Florida Osteopathic Medical Association, the Florida Association of County Health Officers and the Florida Conference of Medical Society Executives. The problem is that in the wake of 1984 amendments to state law, local school boards are accepting health examination certificates signed by chiropractors and other unqualified or limited service providers.



Reference Committee No. II (Public Policy) was chaired by William J. Romanos Jr., M.D., Palm Beach. Left to right: Linda Marraccini, M.D., South Miami; Joseph E. Holland, M.D., Leesburg; Mrs. Kathy Lundy, Recorder; Standing Dr. Romanos; Walter A. Harmon, M.D., Jacksonville; Thomas H. Moore Jr., M.D., Gainesville.

Current FMA policy is that school health examination forms should be signed only by a doctor of medicine or doctor of osteopathy. The June 22 discussions were to address ways to make more medical doctors and osteopaths available to do school physicals and possible amendment to the law in 1987.

The Committee has made some minor modifications to the participation examination physical form that was approved by the House of Delegates in 1985, and these modifications have been reported to the Board of Governors.

In other major actions, the Council and Committee have suggested to the Board of Governors a policy of the admission of AIDS children to school; developed and recommended adoption of a "Model Policy on Communicable Diseases for Florida School Districts;" and called for FMA support of prophylactic use of the Hemophilus Influenzae Type B vaccine in children ages 2 to 5 throughout Florida.

Committee on Substance Abuse

For the second year, Joseph H. Deatsch, M.D., has chaired the Committee on Substance Abuse which has two major projects on the drawing boards at the present time.

In cooperation with the American Medical Association and the University of South Florida College of Medicine, the Committee has developed a CME curriculum on the prescribing of drugs, particularly controlled substances. The course is intended primarily for physicians who have been cited or suspected of overprescribing, choosing improper drugs or other prescription improprieties, although it would be open to any physician who wishes to enroll. It is hoped that the course will be offered for the first time this fall.

The Committee developed a proposed FMA policy statement, which was adopted by the Board of Governors, on Florida's cocaine epidemic. Since cocaine addicts tend to see physicians with some frequency for problems associated with their drug usage, physician education is important. Therefore, the Committee is developing a handbook for Florida physicians which will offer tips on how to recognize the cocaine addict in medical practice. The booklet also will address intervention, treatment and referral.

The Committee continued to monitor the work of the Florida Cocaine Task Force, the Prescription Abuse Data Synthesis (PADS) project, and the Governor's Commission on Alcohol and Drug Concerns.

Supplemental Report Council on Medical Services

The motion of the Reference Committee that the Supplemental Report of the Council on Medical Services be adopted as presented carried.

Proper nutrition is unquestionably an important element in the maintenance of good health in people of all ages. In school-age children, proper diet is especially important.

School food service programs that are offered in public schools thoughout Florida are required by the U.S. Department of Agriculture to offer balanced meals that provide one-third of the Recommended Daily Allowance of Nutrients (RDA). Such programs have carried out their missions as non-profit and self-supporting services without potentially damaging direct competition from the sale of carbonated beverages and so-called "junk foods" on the school grounds.

Florida Administrative Rule 6A-7.42 (Responsibilities for the School Food Service Program) assigns to each district school board the responsibility:

> "To prohibit the sale of food and beverage items in competition with the district approved food service program, including those classified as 'foods of minimum nutritional value' listed in Code of Federal Regulations 210, Appendix B. These items may be sold in secondary schools only, with the approval of the school board, one (1) hour following the close of the last lunch period." [6A-7.42(2)(c)]

The Florida School Food Service Association, Inc., consisting of county school board food service directors and other food service supervisory personnel, supports the rule as it currently exists in that it prohibits competition from vending machine sales. However, other interests, including junior and senior high school principals, are trying to get the rule amended to permit the sale of soft drinks and junk foods at any time during school not only in secondary schools but in junior high schools as well. They maintain that other school programs are suffering because of the ban on soft drink and junk food sales. They see profits from such sales as a source of funding for library books, band uniforms, computers, etc.

Food service directors oppose the liberalization of the rule on the ground that many students would be inclined to spend their lunch money in vending machines rather than purchase wholesome meals which school lunch rooms provide.

The proposed amended rule has been scheduled for a vote by the Florida Cabinet, sitting as the State Board of Education, during the week of September 1. However, the rule was withdrawn, probably because it has generated controversy and Florida is now in the midst of an election campaign. The school food service community expects that it will be resubmitted at a later date.

At its meeting on September 7, the FMA Committee on School Health investigated this controversy and heard presentations from Ms. Barbara S. Correll, M.S., R.D., Director of Food Service for Pinellas County Schools; and Ms. Harriet M. Stark, Assistant Director of Food Service, Pinellas County Schools, and President-Elect of the Florida School Food Service Association, Inc.

It is the belief of the Committee on School Health and the Council on Medical Services that school food service programs, by offering nutritious balanced meals at modest prices, have a very important role in the health and well-being of the school-age child or adolescent. Good nutrition and good health should be promoted by every reasonable means within these age groups.

In today's society the typical school-age child probably consumes more carbonated beverages and junk food than he should outside the school setting. To allow the unrestricted sale of such foods on school grounds no doubt would seriously handicap school lunch programs in the performance of their valuable service.

Recommendation No. 1

THAT THE FLORIDA MEDICAL ASSOCIATION OPPOSE ANY AMENDMENTS TO STATE ADMINISTRATIVE RULE 6A-7.42 (RESPONSIBILITIES FOR THE SCHOOL FOOD SERVICE PROGRAM) THAT WOULD PERMIT THE UNRESTRICTED SALE OF CARBONATED BEVERAGES AND JUNK FOODS ON SCHOOL GROUNDS IN DIRECT COMPETITION WITH SCHOOL FOOD SERVICE PROGRAMS; THAT THE FMA ENDORSE THE PRESENT RULE THAT RESTRICTS THE SALE OF THESE ITEMS TO SECONDARY SCHOOLS ONLY, WITH THE APPROVAL OF THE SCHOOL BOARD, ONE HOUR AFTER THE END OF THE LAST LUNCH PERIOD; AND FURTHER THAT THIS POSITION BE COMMUNICATED INDIVIDUALLY TO EACH MEMBER OF THE FLORIDA CABINET, SITTING AS THE STATE BOARD OF EDUCATION, AND TO ANY NEW CABINET OFFICERS ELECTED DURING THE NOVEMBER 1986 GENERAL ELECTION.

Report B of the Board of Governors

The Reference Committee commended the Board of Governors for its outstanding performance during the year.

A motion of the Reference Committee carried to adopt Recommendation No. B-1.

A motion by the Reference Committee to amend lines 17-20 of Recommendation No. B-2 to read: "members to work locally with leaders in public health, law enforcement and community action agencies, schools, churches, synagogues, parent and teacher organizations, and other groups in developing programs that might help stem the tide of this ever increasing problem" carried.

Recommendation No. B-3 was adopted.

Report B of the Board of Governors was adopted as amended.

Report B
of the
Board of Governors
Luis M. Perez, M.D., Chairman

Board Actions of Major Importance

FMA Councils and Committees

COUNCIL ON MEDICAL SERVICES

The Annual Report of the major activities of the Council on Medical Services is included in this section of the Delegates' Handbook. The Board has reviewed the Council's activities during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Funding for Geriatric Education: The Board approved a petition to Governor Bob Graham and the Florida Committee on Aging to maintain and increase funding for geriatric education at the state's three medical schools which is due to expire in 1986-87. The funds requested would provide three positions in geriatrics at each medical school.

Governor's Task Force on AIDS: The Board recommended to the Governor that he increase the Governor's Task Force on AIDS to add two physicians in private practice to be nominated by the Florida Medical Association.

RECOMMENDATION NO. B-1

ACQUIRED IMMUNE DEFICIENCY SYNDROME: THAT THE HOUSE OF DELEGATES APPROVE THE ADOPTION OF THE FOLLOWING POSITION ON AIDS IN SCHOOL CHILDREN, TEACHERS AND OTHER SCHOOL PERSONNEL:

THE VARIOUS SCHOOL SYSTEMS SHOULD ADDRESS THE OVERALL NEEDS OF IMMUNO-COMPROMISED CHILDREN INCLUDING THOSE WITH AIDS OR ARC, THOSE WITH CONGENITAL ANOMALIES OF THE IMMUNE SYSTEM, THOSE ON IMMUNOSUPPRESSIVE DRUGS FOR THE THERAPY OF VARIOUS CLINICAL ENTITIES SUCH AS COLLAGEN-VASCULAR DISEASES AND MALIGNANCIES, AND THOSE CHILDREN ON IMMUNOSUPPRESSIVE DRUGS AFTER AN ORGAN TRANSPLANTATION.

THE COMPLEXITY OF THE CLINICAL STATUS OF THESE CHILDREN, INCLUDING AN ASSESSMENT OF THE EMOTIONAL IMPACT OF THE DISEASE ON THE CHILD, REQUIRES AN INDIVIDUAL DECISION FOR EACH CHILD, REGARDING HIS/HER INVOLVEMENT IN THE EDUCATIONAL SYSTEM.

THUS, WITH EACH CHILD WHO FALLS INTO ONE OR MORE OF THESE CATEGORIES, THE CHILD'S PHYSICIAN AND A PHYSICIAN REPRESENTING EACH SCHOOL SYSTEM, SHOULD JOINTLY REVIEW ALL THE ASPECTS OF THE CHILD'S HEALTH PROBLEMS AND DEVELOP A PROTOCOL THAT EMPHASIZES THE PARTICULAR NEEDS OF EACH CHILD.

IN THE EVENT THAT SUCH PHYSICIANS ARE NOT AVAILABLE, THE SCHOOL SYSTEM WILL BE REPRESENTED BY THE COUNTY HEALTH OFFICER OR HIS DESIGNEE; AND THE CHILD WILL BE REPRESENTED BY A PHYSICIAN APPOINTED BY THE LOCAL COUNTY MEDICAL SOCIETY.

IN THE EVENT OF A DISAGREEMENT BETWEEN THE INVOLVED PHYSICIANS, THE PROTOCOL TO BE FOLLOWED SHOULD EMPHASIZE THE TOTALITY OF THE HEALTH NEEDS OF ALL THE CHILDREN IN THAT PARTICULAR SCHOOL, INCLUDING THE CHILD UNDER REVIEW.

THE GUIDELINES AND RECOMMENDATIONS OF THE CENTER FOR DISEASE CONTROL (CDC) IN REGARD TO ALL TYPES OF ACTUAL OR POTENTIALLY INFECTIOUS DISEASES, INCLUDING AIDS OR ARC, SHOULD BE UTILIZED AS ONE COMPONENT IN THE DECISION-MAKING PROCESS REGARDING EACH INDIVIDUAL CHILD.

ALL EDUCATIONAL AND PUBLIC HEALTH DEPARTMENTS, REGARDLESS OF WHETHER AIDS-INFECTED CHILDREN ARE INVOLVED, ARE STRONGLY ENCOURAGED TO INFORM PARENTS, CHILDREN AND EDUCATORS REGARDING AIDS AND ITS TRANSMISSION.

SUCH EDUCATION WOULD GREATLY ASSIST EFFORTS TO PROVIDE THE BEST CARE AND EDUCATION FOR INFECTED CHILDREN WHILE MINIMIZING THE RISK OF TRANSMISSION TO OTHERS.

AIDS Funding: The Board agreed to support initiatives in the legislature to provide adequate funding to cover the various services necessary to deal with the problem of acquired immune deficiency syndrome (AIDS), and supported and endorsed informational programs which will update available information to the public and the profession about AIDS which would be coordinated with the Governor's Task Force on AIDS.

Drug Education Performance Standards: The Board endorsed the Florida Alcohol and Drug Abuse Association's "Drug Education Performance Standards K-12" and urged the Florida Department of Education to use this booklet in planning curriculum for kindergarten to grade 12.

Pre-school Physical Exams: The Board encouraged the membership of the Florida Medical Association to cooperate fully with local school boards and county health units in the administration of school entry physical examinations.

Curriculum Guide/Sexually Transmitted Diseases: The Board endorsed both the teacher and student editions of "Venereal Diseases — Other Sexually Transmitted Diseases" which was developed for grades 7-12 by the Venereal Disease Control Program, Health Program Office, Department of Health and Rehabilitative Services, with the assistance of the Northeast Florida Educational Consortium.

Hemophilus Influenza Type B Vaccine: The Board supported the prophylactic use of the hemophilus Type B vaccine in children ages 2 to 5 throughout the state of Florida and appropriate funding for its dissemination.

Medical Group Management Association: The Board agreed to establish liaison with the Medical Group Management Association and endorsed the educational programs of the MGMA that meet the standards of the Accreditation Council for Continuing Medical Education.

Health Manpower Shortage Area Review: The Board assigned the responsibility for processing health manpower shortage area designations and proposed designations received from the Department of Health and Rehabilitative Services to the Committee on Public Health in view of the fact that there is no longer a Committee on Health Manpower.

Policy Statement on Cocaine: The Board approved a proposed policy statement on cocaine addiction for publication in *FMA Today* and distribution to law enforcement agencies.

RECOMMENDATION NO. B-2

THAT THE HOUSE OF DELEGATES ADOPT THE FOLLOWING POLICY STATEMENT ON COCAINE ADDICTION:

The Florida Medical Association, through its participation in the Florida Cocaine Task force, is monitoring the current cocaine epidemic and its impact on personal health, as well as the social, legal, community and economic implications. Cocaine is not a benign substance but rather a highly powerful addicting drug, which leads to potentially devastating physical and emotional consequences, including death. The Florida Medical Association intends to remain a leader in the field of education, prevention and treatment of this serious drug problem currently infecting our communities and impacting on the lives of all age groups, particularly the young and middle-aged. The Association strongly encourages its members to work locally with leaders in public health, and law enforcement, community action agencies, schools, churches, synagogues, parent and teacher organizations, and other groups, in developing programs that might help stem the tide of this ever-increasing problem.

RECOMMENDATION NO. B-3

Allied Professions: THAT THE HOUSE OF DELEGATES AMEND ITS POLICY ADOPTED AT THE 1986 INTERIM MEETING REGARDING THE STATEMENT ON ALLIED PROFESSIONS SO THAT THE STATEMENT WILL READ:

"The FMA opposes the independent practice of medicine by the nursing profession, including nurse anesthetists, nurse midwives and lay midwives."

Prescription Drug Education: The Board approved the prescription drug re-education curriculum for physicians entitled "Protecting Your Medical Practice: Clinical, Legal and Ethical Issues in Prescribing Abusable Drugs," as developed by the Committee on Substance Abuse with the assistance of the AMA.

Donald I. Macdonald, M.D.: The Board commended Dr. Donald I. Macdonald for his many contributions in the field of substance abuse as Chairman of the Committee on Substance Abuse, in his role as Acting Assistant Secretary for Health Affairs in the Department of Health and Human Services and as Administrator of the Federal Alcohol, Drug Abuse and Mental Health Administration.

Legislative Advisors/Committee on Aging: The Board approved and referred to the President-Elect for implementation the recommendation that a State Senator and Representative be requested to serve in an advisory capacity to the FMA Committee on Aging.

Diabetic Retinopathy Project: Endorsed the Department of Health and Rehabilitative Services project on diabetes control.

Participation Physical Examination Forms: The Board approved the revised Duval County Public Schools Activities Medical Examination form as a prototype or model for participation physical examination forms in other public school jurisdictions in Florida.

College Entry Immunizations: The Board approved and referred to the Council on Legislation the recommendation that the FMA sponsor an amendment to the Florida Statutes that would require needed immunizations for entry into all Florida institutions of higher learning, thereby controlling and preventing the spread of childhood diseases to college students.

Diabetes Control Medications: The Board approved and referred to the Council on Legislation the recommendation that the FMA sponsor an amendment to the Florida Statutes that would permit the supplying of all necessary diabetes control medications, not merely Insulin, to individuals with financial instability.

Swimming Pools, Bathing Places, Mobile Home Parks, and Migrant Labor Camps: The Board approved FMA support for amendments to the Florida statutes regarding public swimming pools and bathing places, mobile home parks, and migrant labor camps, to provide that fees be increased to a level sufficient to meet the cost of services in all parts of the state in place of allowing counties to establish reasonable additional fees by resolution or ordinance.

Potential Radiation Risks: The Board approved FMA support for legislation that would require that prospective home buyers/owners be notified of any potential radiation risk.

Standards for Private Wells: The Board authorized the FMA to seek the establishment of a statutory mandate to set construction and bacteriological standards for private wells in Florida.

Occupational Health Services: The Board authorized the FMA to urge the Legislature to appropriate funds to the Department of HRS to identify potential needs, and plan and implement a program to assure necessary occupational health services are available throughout Florida.

Public Health Nurses/Dispensing: The Board approved FMA support for an amendment to the Florida Statutes that would correct the current problem concerning the dispensing of prescription drugs under physician order by public health nurses.

Report F of the Board of Governors

1985 House of Delegates Referrals

Resolutions 85-17 and 85-23 were considered by Reference Committee No. II and upon recommended action of the Reference Committee, Resolutions 85-17 and 85-23 were filed. See Reference Committee No. III for Report F of the Board of Governors.

RESOLUTION 86A-9
Labeling of Prescription Drugs
Lee County Medical Society

Resolution 86A-9 was adopted.

RESOLUTION 86A-9

Labeling of Prescription Drugs

RESOLVED, The FMA intercede with the Florida Board of Pharmacy to have instituted the requirement that all prescriptions for trade name drugs when filled with generic drugs be labeled in the following or similar manner:

Drug prescribed: "Trade Name"
Drug dispensed: "Generic Name"

and be it further

RESOLVED, If the FMA fails in the previous negotiations with the Pharmacy Board, then the FMA will attempt through the legislative process to accomplish this goal.

RESOLUTION 86A-26
Reduced Fee School Examinations
Dade County Medical Association

A Substitute Resolution 86A-26 was offered by the Reference Committee which was amended by Dr. Clinton J. McGrew Jr., of Hernando County by offering an additional resolve. Substitute Resolution 86A-26 was adopted as amended.

SUBSTITUTE RESOLUTION 86A-26

Reduced Fee School Examination

RESOLVED, That the Florida Medical Association encourage each county medical society to provide a mechanism for all counties within their jurisdiction whereby school physical examination can be made more available to low income individuals through qualified physicians;

RESOLVED, That the Board of Governors develop an appropriate recognition for those physicians who give of their time to serve the communities of Florida in this important area, and be it further;

RESOLVED, That the FMA pursue strengthening of the existing Florida Good Samaritan Law to provide better protection for physicians donating their time in conducting school sports preparticipation physical examinations, and physicians donating their time on or off the field for junior high and high school sports programs.

RESOLUTION 86A-30
Generic Substitutions
Pinellas County Medical Society

The Reference Committee recommended that Resolution 86A-30 be amended by adding the words "the AMA" on line 11 between "Delegation" and "and FDA."

Resolution 86A-30 was adopted as amended.

RESOLUTION 86A-30

Generic Substitutions

RESOLVED, That the Florida Medical Association, with members of the Florida Congressional Delegation, the AMA, and FDA officials, seek legal remedies in updating the 1938 Food, Drug and Cosmetic Act to permit proper labeling and classification of the non-therapeutically equivalent drugs.

RESOLUTION 86A-33
Regulatory Pain and Sleeping Medications
Duval County Medical Society

The motion of the Reference Committee that Resolution 86A-33 be referred to the Board of Governors because of liability considerations carried.

RESOLUTION 86A-33

Regulatory Pain and Sleeping Medications

(Referred to Board of Governors)

Whereas, the Department of Professional Regulations monitors physician practices of prescribing certain types of analgesics and sedatives; and

Whereas, some patients suffer from chronic, irreversable illness characterized by severe pain; and

Whereas, the only available treatment for some of these patients may be continued analgesics and/or sedatives; and

Whereas, the Department of Professional Regulations has not informed the medical profession what criteria they use when reviewing physicians prescribing practices, therefore be it

RESOLVED, That the Florida Medical Association develop appropriate prescribing guidelines for use by physicians for the treatment of patients suffering from severe chronic pain; be it further

RESOLVED, That after prescribing guidelines are developed, they be presented to the appropriate state governmental agency as the community standard in Florida for the treatment of these types of patients; and be it further

RESOLVED, That these prescribing guidelines be reviewed and modified as appropriate annually by the Florida Medical Association to assure that they are current with existing medical practice in Florida.

The Reference Committee expressed its appreciation to all members of the Association who appeared at the meeting to provide guidance and counsel, and to Dr. Joseph T. Ostroski, Chairman of the Council on Medical Services.

Special thanks were conveyed to Kay K. Hanley, M.D., the AMA Delegate at the meeting of the Reference Committee. The Chairman expressed his sincere appreciation to members of the Committee: Thomas H. Moore Jr., M.D.; Joseph E. Holland, M.D.; W. Alan Harmon, M.D.; and Linda A. Marraccini, M.D.

The Reference Committee also thanked FMA staff, Mr. Edward D. Hagan and Mrs. Kathy Lundy for their assistance in the preparation of the report.

The motion of the Reference Committee that the report of Reference Committee No. II, Public Policy, be adopted as amended carried.

EMERGENCY RESOLUTION
Voluntary Drug Testing for Physicians
Broward County Medical Association

A motion from the floor carried to adopt an emergency resolution as presented by Dr. Peter A. Tomasello, Broward County.

EMERGENCY RESOLUTION

Voluntary Drug Testing for Physicians

Whereas, morbidity and mortality rates for adolescents are 11% higher today than in 1966, due in part to substance abuse with ⅔ of American youth using an illicit drug before they finish high school, and

Whereas, AMA is embarked on a program of establishing guidelines on diagnosis, treatment and referral of adolescent substance abusers, to be incorporated in the forthcoming revisions of AMA handbooks on alcoholism and drug abuse, and

Whereas, certain of our folk heroes have been found suspect in this area, and others have provided leadership through public and voluntary submission to testing, it is

RESOLVED, That the physicians of Florida who have vowed to preserve life and public health, and who by education and training are role models adopt a policy of voluntary substance abuse testing, and be it further

RESOLVED, That the FMA Delegates to the AMA House of Delegates memorialize that body to adopt substance abuse testing as a policy to discourage and curtail the usage of harmful substances by our populace.

Dr. Selander then introduced Dr. Robert E. Windom, Assistant Secretary for Health, Department and Human Services, who addressed the House. Dr. Frank C. Coleman presented Dr. Windom with a plaque for his contributions as a Board member to the Florida Physicians Insurance Company.

Dr. James B. Perry expressed his appreciation to the House for passing the Emergency Resolution on Voluntary Drug Testing for Physicians.



Dr. Robert E. Windom, Assistant Secretary of Health, Department of Human Services addresses the House.



Dr. Windom and Dr. J. Lee Dockery.



Dr. Windom accepts a plaque for his contributions as a Board Member to the Florida Physicians Insurance Company from Dr. Frank C. Coleman.



FMA Staff members with Dr. Windom. Left to right: E. Russell Jackson; Robert C. Fore, Ed.D.; Dr. Windom and Robert W. Seligson.

Report of Reference Committee No. I Health and Education

Dr. Selander called the Chairman and members of Reference Committee No. I, Health and Education, to present the report.

Dr. O. Frank Agee, Chairman, and his committee came forward to present the report of Reference Committee No. I, Health and Education.

Report of the Council on Scientific Activities

The motion of the Reference Committee that the Report of the Council on Scientific Activities be adopted as presented carried.

Council on Scientific Activities
Pierre J. Bouis Jr., M.D., Chairman

The Council on Scientific Activities has concluded another successful and active year including one meeting of the Committee on Scientific Publications and two meetings of the Committee on Medical Education. The first meeting was a joint meeting of the Committee on Medical Education and the Florida Medical Foundation Committee on Continuing Medical Education on October 4, 1985 in Orlando. A meeting of the Committee on Scientific Publications followed on October 5, 1985, in Orlando and the final meeting of the Committee on Medical Education was held on May 16, 1986 in Tampa. The Council's work is summarized under the heading of each committee.

Committee on Medical Education

Orris O. Rollie, M.D., Orlando, has completed another active year as Chairman of the Committee. Major activities of the Committee have centered on the 112th Annual Meeting Scientific Program, FMA accreditation of hospital and organization continuing medical education programs, and new continuing medical edcation requirements for medical licensure. Additionally, one of the most significant developments of the year was the elimination of FMA Mandatory credit which was replaced by AMA Category I credit on Februrary 1, 1986.

Annual Meeting Scientific Program

The Committee has coordinated a scientific program of the highest educational quality for the 112th Annual Meeting in collaboration with FMA recognized specialty groups. Several program highlights will include a "Symposium on the Care of the Aging Patient," "Risk Management Seminar," and "Maximizing Third-Party Reimbursement and Minimizing Rejected Claims and Reviews." Additional attractions will include programs on chemical dependency, workers' compensation, Wyeth Auto Tutors, the Board of Medical Examiners, and many technical, scientific, and educational exhibits. As has become tradition, the Annual Meeting Scientific Program will offer a total of 20 hours of AMA Category I approved continuing medical education credit. Additional joint-sponsorship by the University of South Florida College of Medicine, the University of Florida College of Medicine, and the University of Miami School of Medicine will be included.

Leadership Conference

For the first time, the Committee on Medical Education in collaboration with the Florida Medical Foundation Committee on Continuing Medical Education sponsored a program for CME sponsors at the Leadership Conference. The workshop included such topics as "The ACCME Essentials for Accreditation," "Improving the Relevancy of CME," "The Accreditation Survey Team," "Promoting Your CME Programs," and "Preparing for the On-site Visit." The workshop received an excellent evaluation and plans are being considered to hold an annual workshop for CME sponsors.

Accreditation

Since the last Annual Meeting, the following accreditation actions have been taken:

- American Heart Association, Suncoast Chapter, Reaccredited for a two-year period from August 19, 1984 to August 18, 1986.
- American Hospital of Miami, accreditation was suspended as of January 13, 1986.
- Baptist Hospital, Pensacola, reaccredited for a two-year period from August 10, 1985 to August 9, 1987.
- Bayfront Medical Center, accreditation suspended as of Februrary 24, 1986, due to affiliation with USF College of Medicine.
- Bethesda Memorial Hospital, granted two-year provisional accreditation from February 14, 1986 to Februrary 13, 1988.
- Florida Lung Association, accreditation suspended as of June 11, 1986.
- Hollywood Memorial Hospital, reaccredited for a six-year period from December 14, 1984 to December 13, 1990.
- Lakeland Regional Medical Center, reaccredited for a six-year period from February 7, 1985 to February 6, 1991.
- Orlando Regional Medical Center, reaccredited for a six-year period from December 14, 1984 to December 13, 1990.
- Tallahassee Memorial Regional Medical Center, reaccredited for a six-year period from January 29, 1985 to January 28, 1991.
- University Community Hospital, reaccredited for a two-year period from April 8, 1985 to April 7, 1987.

Committee on Scientific Publications

R.G. Lacsamana, M.D., has completed his first year as Editor of *The Journal of the Florida Medical Association*, and Chairman, Committee on Scientific Publications. Since becoming Editor in June of 1985, *The Journal of the Florida Medical Association* has published 58 scientific articles, 15 special articles, 17 medical

economics articles, 37 editorials, 37 letters and viewpoints and 41 encores. Included in these statistics are over 150 authors. For the first time in several years, the Committee on Scientific Publications offered a workshop for county medical society and auxiliary bulletins. The workshop was highly successful and included representatives from 11 county medical societies, the FMA, and the FMA-A. Workshop participants were enthusiastic in their evaluations and requested that future workshops be offered on an annual basis.

Report of the Council on Specialty Medicine

The motion of the Reference Committee that the Report of the Council on Specialty Medicine be adopted as presented carried.

Council on Specialty Medicine
W. Thomas Hawkins, M.D., Chairman

The Council on Specialty Medicine held three meetings during the 1985-86 Association year: November 16, 1985; January 25, 1986; and May 17, 1986. Thirty recommendations were approved by the Council and submitted to the Board of Governors.

At its initial meeting In November, the Council attempted to organize itself into ad hoc committees in order to divide the Council's workload. The following ad hoc committees were identified and actually met on January 24, 1986, prior to the full Council meeting: (1) Committee on Specialty Codes, Relative Value Studies, and Workers' Compensation; (2) Liaison Committee to the PRO Committee; (3) Committee on Perinatal Care; (4) Committee on Internal Affairs of the Council; (5) Committee on Alternative Delivery Systems; and (6) Committee on Legislation and Malpractice. It was the consensus of the Council members that the ad hoc committees would enable the Council to provide input to the Board on the substantive areas of responsibility assigned to each committee. Concern was expressed by some members, however, that the ad hoc committees duplicated existing committees within other councils of the FMA. The final recommendation to the Board of Governors to establish ad hoc committees was reduced in number from six to four. They were: (1) Committee on Medical Services, Programs, and Economics; (2) Committee on Legislation; (3) Committee on Internal Affairs of the Council on Specialty Medicine; and (4) the Committee on Health Manpower. This recommendation was referred to the Board of Governors.

The Council on Specialty Medicine is comprised of 38 FMA recognized specialty groups representing the major areas of medical practice. Many issues were considered by the Council. These issues included the following:

1. *Professional Foundation for Health Care*: The Council recommended that the president of each specialty group recognized by the FMA appoint two physicians per specialty in each of three areas of the state (north, central and south) to provide consultation to the Professional Foundation for Health Care, Inc., (the statewide PRO) as may be needed to assure that quality of care standards are applied on a routine basis by the PRO throughout the state. The Council also recommended that the FMA endorse the establishment of quality assurance committees by the Professional Foundation for Health Care, Inc., for the purpose of reviewing and monitoring actions taken by hospital quality assurance committees.
2. *Monitoring of Pharmacists*: The Council expressed a major concern with the record-keeping by pharmacists who prescribe under the new law and related rules pertaining to pharmacists prescribing. The Council recommended that enforcement of this law be monitored to the fullest extent possible.
3. *Optometrists*: The Council reflected the concern of the Florida Society of Ophthalmology regarding encroachments by optometrists by recommending that the FMA oppose any legislative proposal that would extend drug use, surgery or prescription authority to optometrists and, if such a bill did pass, to urge the Governor to veto it.
4. *Legislative Program*: The Council expressed its support and endorsement regarding the FMA's legislative program for 1986. It especially expressed support for the Board of Governors' position on certificate of need, the reorganization of HRS and indigent health care.
5. *Relative Value Studies*: The Council recommended that the FMA encourage the Department of Labor and Employment Security to utilize the 1986 Relative Value Studies in the development of Workers' Compensation fee schedules.
6. *Medicaid*: The Council was unanimous in its opinion that the Medicaid reimbursement levels are abominable, and recommended that the Medicaid reimbursement levels be re-evaluated by HRS.
7. *Perinatal Care*: The Council made a series of recommendations pertaining to the enhancement of the ability of persons to receive perinatal care, and for the state to make the tort and insurance environments in Florida viable for obstetricians to practice medicine.
8. *FMA Membership Variance*: The Council recommended in November of 1985 that the FMA expand its current allowance of 10 percent variance from FMA membership by a recognized specialty group to 25 percent variance. This recommendation was disapproved by the Board of Governors. In May, the Council voted to recommend to the Board of Governors that a 20 percent variance be allowed. Additionally, the Council voted to have a position paper and resolution drawn up for its consideration that would eliminate the specific percentage variance allowable for specialty group variance.
9. *Specialty Group Recognition*: The Council approved continuing recognition for the following specialty groups which have met the criteria established by the FMA House of Delegates, and which were due for specialty recognition during the 1986 FMA year:

 Florida Allergy & Immunology Society
 Florida Chapter, American College of Chest Physicians
 Florida Society of Colon & Rectal Surgeons
 Florida Chapter, American College of Emergency Physicians
 Florida Society of Internal Medicine
 Florida Society of Nephrology
 Florida Neurosurgical Society
 Florida Obstetric & Gynecologic Society
 Florida Society of Ophthalmology
 Florida Society of Otolaryngology
 Florida Society of Pediatric Cardiologists
 Florida Association of Pediatric Surgeons
 Florida Society of Preventive Medicine
 Florida Radiological Society
 Florida Chapter, American College of Surgeons
 Florida Thoracic Society

 Of the nineteen specialty groups due for specialty recognition during the 1985-1986 FMA year, three groups did not meet the criteria. They were: (1) Florida Academy of Family Physicians (only 85 percent of its members are FMA members); (2) Florida Region, American College of Physicians (only 72 percent of its members are FMA members); (3) Florida State Surgical Division, International College of Surgeons (did not submit an application). The Council recommended to withhold taking action on the specialty recognition renewal application of the Florida Academy of Family Physicians and the Florida Region, American College of Physicians until the next meeting of the Council; and that the Florida State Surgical Division, International College of Surgeons, be placed on



Reference Committee No. I (Health and Education) was chaired by O. Frank Agee, M.D., Gainesville. Left to right: Alvin E. Smith, M.D., Ormond Beach; Niguel Figueroa, M.D., North Miami Beach; Donald J. Plevy, M.D., Plantation; Robert J. Brueck, M.D., Fort Myers; Terence P. McCoy, M.D., Tallahassee; Mrs. Dawn Gerik, Recorder; standing, Dr. Agee.

probation if completed recognition forms meeting specialty recognition criteria are not received by August 1, 1986.

10. *Specialty Groups on Probation:* Two of the three specialty groups which were placed on probation by the House of Delegates at the 1985 Annual Meeting have now met the criteria for specialty society recognition. They are: (1) the Florida Occupational Medical Association; and (2) the Council of Florida District Branches, American Psychiatric Association. The following specialty group, which was placed on probation at the 1985 Annual Meeting, has not submitted an application for recognition in order to be taken off probation: the Florida Association of Nuclear Physicians. The Council voted to recommend that the FMA grant full specialty group recognition to the Florida Occupational Medical Association and the Council of Florida District Branches, American Psychiatric Association; and that the Florida Association of Nuclear Physicians continue on probation if a completed recognition form meeting specialty group recognition criteria is not received by August 1, 1986.

11. *New Specialty Group Recognition:* The Council recommended that the FMA grant specialty group recognition to the Florida Society of Dermatologic Surgeons. The Florida Society of Dermatologic Surgeons submitted an application for initial recognition by the FMA. The application of this specialty group showed 108 FMA members and 8 non-FMA members for an FMA percentage membership of 93 percent, and that the group had met the other specialty group criteria. Sentiment was expressed among the members of the Council that the Florida Society of Dermatologic Surgeons is a group that performs functions different from the Florida Society of Dermatology; and, further, that it is a group with sufficient members seeking recognition; and as such the Council should recommend that they be recognized by the FMA.

Report A of the Board of Governors

The Reference Committee expressed its appreciation to Dr. R.G. Lacsamana for his outstanding work with *The Journal of the Florida Medical Association, Inc.*, during his first year as Editor.

The Reference Committee noted that on page I-7, line 17, the number of credit hours should be changed from "up to 20 hours" to "up to 15 hours AMA Category I credit," and page I-8, line 105, the spelling of the word "surgery" should be corrected to read "surgery."

Recommendation No. A-1 was adopted as presented.

Recommendation No. A-2, Resolution 86A-7 and Resolution 86A-8 dealt with the same information and were considered together. There was considerable discussion concerning the variance percentage and the Reference Committee recommended that the percentage be changed to 25%. The Reference Committee also noted that on page I-8, line 59, the words "reaffirm current" be changed to "establish an." This amendment was in lieu of Resolutions 86A-7 and 86A-8. The motion of the Reference Committee that Recommendation A-2 be adopted as amended carried.

Recommendation No. A-3 was adopted as presented.

The motion of the Reference Committee to adopt Report A of the Board of Governors as amended carried.

Report A of the Board of Governors

Luis M. Perez, M.D.

COUNCIL ON SCIENTIFIC ACTIVITIES

The Annual Report of the major activities of the Council on Scientific Activities is included in this section of the Delegates' Handbook. The Board of Governors has reviewed the Council's activities during the past Association year and submits the following

report and/or recommendations to the House regarding each of the items addressed by the Council.

1986 Annual Meeting: The Board established the format for the 1986 Annual Meeting, September 18-21, 1986 at the Diplomat Hotel in Hollywood, Florida.

It is expected that some 27 specialty societies will offer scientific programs and up to 15 hours AMA Category I credit may be earned.

CME Relicensure Requirement: The Board authorized the Council to offer its assistance to the Department of Professional Regulation in developing rules related to the new CME relicensure requirement which would include a reporting mechanism, acceptable categories of credit and identification of acceptable CME sponsors. The FMA is seeking to enter into an agreement with the Department of Professional Regulation that would allow FMA to participate in administration of the program.

FMA Mandatory Credit: The Board approved the recommendation that the FMA's mandatory credit category for continuing medical education be replaced by AMA Category I credit as the acceptable category of credit applicable to FMA continuing medical education requirements; and further that the current approval procedure for granting the FMA mandatory credit be discontinued no later than February 1, 1986. In keeping with the request of the House of Delegates at its Annual Meeting in 1985, the format for the meeting has been reduced from a 5-day to a 4-day meeting. The Board also determined that the Annual Meeting tentatively be scheduled to be held at the Diplomat Hotel for the forseeable future until such time as competitive rates and costs for the Annual Meeting can be obtained at alternate locations in Florida.

CME Accreditation Fees: The Board of Governors approved an increase in accreditation fees from the current fees of $200 for initial survey and $100 for resurvey to $500 and $250 respectively.

The FMA has served as the accreditor of intrastate sponsors of continuing medical education since 1974, and during that period of time, accreditation fees have never been increased. The Accreditation Council for Continuing Medical Education (ACCME), which accredits national sponsors, charges $1,800 for initial applications and $1,000 for resurvey. Data from other state medical associations show a range of fees from $50 to $650. The Board felt that an increase in fees was in order.

CME Fees for Joint-Sponsorship: The Board requested the Florida Medical Foundation Committee on Continuing Medical Education to re-examine its application fee schedule for CME joint sponsorship and consider an increase to at least $100 for up to six hours credit and $200 for over six hours credit.

The Florida Medical Foundation Committee on Continuing Medical Education has charged $25 for up to six hours credit and $50 for over six hours credit for applications for joint sponsorship since the program began in 1977. The current fee schedule is so low that many applicants seek FMF joint sponsorship when they should more properly seek joint sponsorship from an ACCME nationally accredited sponsor due to the desire to advertise outside of Florida.

FMA Journal Editor: The Board enthusiastically approved the president-elect's nomination of Remigio G. Lacsamana, M.D., Daytona Beach, for re-appointment as Editor of the Journal of the Florida Medical Association for 1986-87. The Board commended Dr. Lacsamana and the entire editorial staff for the continuing growing excellence of *The Journal.*

JFMA Advertising Principles: The Board considered recommendations from the Committee on Scientific Publications regarding advertising in FMA publications.

RECOMMENDATION NO. A-1

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING PRINCIPLES GOVERNING ADVERTISING IN ALL PUBLICATIONS OF THE FLORIDA MEDICAL ASSOCIATION:

THE FLORIDA MEDICAL ASSOCIATION SEEKS TO PROMOTE THE SCIENCE AND ART OF MEDICINE AND THE BETTERMENT OF PUBLIC HEALTH. IN SERVING THESE AIMS, THE FMA COMMUNICATES REGULARLY WITH THE MEMBERS OF THE MEDICAL PROFESSION, WITH PROFESSIONAL PERSONS IN ALLIED FIELDS, AND WITH THE PUBLIC. A SUBSTANTIAL PART OF THIS COMMUNICATION IS CARRIED OUT THROUGH THE REGULAR PRODUCTION AND DISTRIBUTION OF ITS PUBLICATIONS.

THE APPEARANCE OF ADVERTISING IN FMA PUBLICATIONS IS NOT AN FMA GUARANTEE OR ENDORSEMENT OF THE PRODUCT BY THE MANUFACTURER. THE FACT THAT AN ADVERTISEMENT FOR A PRODUCT, SERVICE OR COMPANY HAS APPEARED IN THE FMA PUBLICATION SHALL NOT BE REFERRED TO IN COLLATERAL ADVERTISING.

AS A MATTER OF POLICY, THE FMA WILL SELL ADVERTISING SPACE IN ITS PUBLICATIONS WHEN (1) THE BUYER BELIEVES PURCHASE OF SUCH SPACE REPRESENTS A SOUND EXPENDITURE, AND (2) THE INCLUSION OF ADVERTISING MATERIAL DOES NOT INTERFERE WITH THE PURPOSE OF THE PUBLICATION.

THESE PRINCIPLES ARE APPLIED BY THE FLORIDA MEDICAL ASSOCIATION IN DETERMINING THE ELIGIBILITY OF PRODUCTS AND SERVICES FOR ADVERTISING IN FMA SCIENTIFIC PUBLICATIONS — *THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.* AND IN THE *FMA TODAY* NEWSPAPER.

THE FLORIDA MEDICAL ASSOCIATION RESERVES THE RIGHT TO REFUSE ADVERTISING IN ANY OF THE ASSOCIATION'S PUBLICATIONS, WHICH IT CONSIDERS TO CONTRADICT OR CONTRAVENE IN ANY MANNER, THE GOALS AND PURPOSES OF THE FMA, AS SET FORTH IN THE ASSOCIATION'S BYLAWS.

HMO Advertising: The Board disapproved any modifications of the current FMA policy not allowing advertising by health maintenance organizations in the *FMA Journal.*

SMJAB Report: The Board was pleased to receive a report that the State Medical Journal Advertising Bureau (SMJAB) list the JFMA as third ranked behind *The New England Journal of Medicine* and *JAMA* in total number of pages in national advertising. As *NEJM* and *JAMA* are not state publications, the *JFMA* is clearly number one compared to other state medical association journals.

The content of the *JFMA* from June 1985 through June 1986 included:

58 Scientific Articles, 133 Authors
15 Special Articles, 22 Authors
17 Medical Economics Articles
37 Editorials
37 Letters & Viewpoints
41 Encores!

Bulletin Workshops: The Board authorized funds to support a workshop for county medical societies and auxiliary bulletins which was highly successful and attended by representatives from 11 county medical societies, the FMA and FMA-A.

COUNCIL ON SPECIALTY MEDICINE

The Annual Report of the major activities of the Council on Specialty Medicine is included in this section of the Delegate's Handbook. The Board has reviewed the Council's activities during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Professional Foundation for Health Care: The Board approved the appointment of two physicians per specialty in each of three areas of the state — north, central and south. The appointments would be made by the presidents of each recognized specialty group and the objective would be to provide consultation to the PRO as

needed to assure that quality of care standards are applied on a routine basis throughout the state.

Monitoring of Pharmacists: The Board expressed its desire that the law and rule enabling pharmacists to prescribe be monitored to the fullest extent possible to assure compliance.

Optometrists: The Board reaffirmed the FMA's opposition to any proposal that would extend drug use, surgery, or prescription authority to optometrists.

Specialty Group Recognition: The Board considered a recommendation that the FMA allow a 25% variance from the requirement of 100% FMA membership as a criteria for specialty groups recognition by FMA. Current House of Delegates policy allows the Board of Governors to allow up to a 10% variance if warranted. However, it was also recommended by the Council that if 25 percent variance is allowed it should be only under the following conditions: That non-FMA members of a recognized specialty group not be a delegate to the House of Delegates; that non-FMA members not be appointed to the Council on Specialty Medicine; that non-FMA members be prohibited from holding office in the recognized specialty group; and that non-FMA members be prohibited from voting on FMA business. The Council expressed its opinion that rather than adversely affecting FMA membership, the conditions making a 25 percent variance allowable could serve as an incentive to increase FMA membership within the various specialty groups.

The Board thoroughly discussed the Council's recommendation and the current policy of the Association regarding recognition of specialty groups.

RECOMMENDATION A-2

THAT THE HOUSE OF DELEGATES ESTABLISH AN FMA POLICY THAT THE CRITERIA FOR SPECIALTY GROUP RECOGNITION BY THE FMA INCLUDE THE REQUIREMENT THAT 100% OF THE ACTIVE ELIGIBLE MEMBERS OF THE SPECIALTY GROUP SHALL ALSO BE MEMBERS OF THE FMA AS A CONDITION OF RECOGNITION AND THAT THE FMA BOARD OF GOVERNORS BE AUTHORIZED TO ALLOW A 25% VARIANCE TO THE REQUIREMENT IF WARRANTED.

Specialty Classification: The Board approved the recommendation that the FMA follow AMA codes for self-designated practice specialties for use in the FMA medical directory and that the Council on Specialty Medicine monitor the directory for accuracy in the correct use of specialty classifications.

Council on Legislation: The Board disapproved the recommendation that each specialty group represented on the Council on Specialty Medicine have a member on the FMA's Council on Legislation.

It was noted that all county medical societies and specialty groups are invited to attend meetings of the Council.

Board of Medical Examiners: The Board referred to the Council on Legislation for review the recommendation that FMA support legislation to separate the Board of Medical Examiners from the Department of Professional Regulation and that the SBME serve as a free-standing and independent licensing board.

Liability Coalitions: The Board thanked the Council for its action in support of the FMA's participation in coalitions involving industry, municipal governments and other entities concerned with the liability insurance problem, which includes the tort system, with a system similar to workers' compensation, with no compensation to be awarded except for negligence.

Election of FMA Officers: The Board referred to the FMA Bylaws Committee the recommendation that participation in the election of FMA Officers and members of the Board of Governors be expanded to all members of the FMA.

Monitoring of Pharmacists: The Board approved the recommendation that enforcement of the law and related rule enabling pharmacists to prescribe be monitored to the fullest extent possible to assure compliance.

Legislative Program: The Board acknowledged with appreciation the action of the Council expressing its support and endorsement of the FMA's legislative professional liability program for 1986 with special emphasis for support of the Board's position on certificate of need, the reorganization of HRS and indigent health care.

Optometrists: The Board approved the recommendation that the FMA oppose any proposal that would extend drug use, surgery or prescription authority to optometrists.

Amendment to Optometric Drug Practice: The Board referred to the Council on Legislation for review the recommendation that in the event a bill passes expanding optometric practice authority and a resulting Governor's veto of the Optometric Practice Act is overturned, the FMA sponsor an amendment to the Optometric Drug Act which would deny optometrists drug use, surgery and prescription authority.

Specialty Society Medical Expertise: The Board approved the recommendation that the FMA encourage specialty societies to develop panels of physicians to work with the statewide PRO in developing criteria and objectives of the PRO and to provide medical input in these specialties as needed.

Article on PRO Activities: The Board approved and referred to the FMA Public Relations Officer for appropriate action the recommendation that the FMA publish an article in the *FMA Journal* and *FMA Today* for the purpose of educating the membership on how the statewide PRO functions including detailing the mechanism of the review process and the need to properly document medical records.

Medicaid: The Board authorized the FMA to request the Department of Health and Rehabilitative Services and the Legislature to re-evaluate Medicaid reimbursement levels.

RECOMMENDATION NO. A-3

SPECIALTY GROUP RECOGNITION: THAT THE HOUSE OF DELEGATES APPROVE CONTINUING RECOGNITION OF THE FOLLOWING SPECIALTY GROUPS WHO HAVE MET THE CRITERIA ESTABLISHED BY THE FMA HOUSE OF DELEGATES FOR RECOGNITION BY THE ASSOCIATION:

Florida Allergy and Immunology Society
Florida Chapter, American College of Chest Physicians
Florida Society of Colon and Rectal Surgeons
Florida Chapter, American College of Emergency Physicians
Florida Society of Internal Medicine
Florida Society of Nephrology
Florida Neurosurgical Society
Florida Obstetric and Gynecologic Society
Florida Society of Ophthalmology
Florida Society of Otolaryngology
Florida Society of Pediatric Cardiologists
Florida Society of Pediatric Surgeons
Florida Society of Preventive Medicine
Florida Radiologic Society
Florida Chapter, American College of Surgeons
Florida Thoracic Society

AND FURTHER, THAT THE HOUSE OF DELEGATES GRANT RECOGNITION TO THE FLORIDA SOCIETY OF DERMATOLOGIC SURGEONS.

The Board also directed that the Florida State Surgical Division, International College of Surgeons, be placed on probation if the completed recognition form is not received by August 1.

Full recognition was granted to the Florida Occupational Medical Association and the Council of Florida District Branches, American Psychiatric Association. (These two specialty groups were placed on probation by the House in 1985 and have now met the criteria for recognition).

The Florida Association of Nuclear Physicians was continued on probation and the Council has been requested to clearly define

the conditions and length of probationary status not to exceed one year.

RESOLUTION 86A-7
FMA Membership in Specialty Societies
Jimmie D. Moore, M.D., Delegate
Florida Society Anesthesiologists

Resolution 86A-7 was not adopted.

RESOLUTION 86A-8
Membership Requirements for FMA-Recognized Specialty Groups
George A. Gant, M.D., Delegate
Florida Academy of Family Physicians

Resolution 86A-8 was not adopted.

RESOLUTION 86A-2
Nasogastric Tubes
Sarasota County Medical Society

The motion of the Reference Committee to adopt and refer to the Board of Governors for implementation and negotiations with the Department of Health and Rehabilitative Services to modify the rules governing care of the terminally ill relating to acceptable standards of medical care carried.

RESOLUTION 86A-2

Nasogastric Tubes

(Adopted and Referred to Board of Governors)

Whereas, nasogastric tubes are artificial devices that require special training and care to utilize, and

Whereas, nasogastric tubes are uncomfortable and disturbing to the patient, and

Whereas, nasogastric feeding tubes are irritating to the esophagus and may endanger the life and health of the patient by inducing irritation and possible bleeding or ulceration of the esophagus, as well as aspiration of material into the lungs with resultant pneumonia, and

Whereas, the AMA Council on Ethical and Judicial Affairs in New Orleans on March 15, 1986, declared there is no ethical difference between removal of respirators and artificial nutrients which may be administered by a nasogastric feeding tube, and

Whereas, the Appellate Court of Florida recently ruled that the right of privacy protected by the United States Constitution demands that all such life-sustaining procedures may, at the request of the patient, be removed; therefore be it

RESOLVED, That all life sustaining mechanisms, including nasogastric tubes, be administered only by order and under the direction of the patient's personal physician.

The Reference Committee expressed its appreciation to all members of the Association who appeared at the meeting to provide guidance and counsel.

Special thanks were conveyed to Richard G. Connar, M.D., and J. Lee Dockery, M.D., who represented the AMA Delegation at the meeting of the Reference Committee. The Chairman expressed his sincere appreciation to the members of the Committee: Robert J. Brueck, M.D.; Miguel Figueroa, M.D.; Terence P. McCoy, M.D.; Donald J. Plevy, M.D.; and Alvin E. Smith, M.D.

The Reference Committee also thanked FMA staff Dr. Robert C. Fore and Mrs. Dawn Gerik for their assistance in the preparation of the report.

The motion of the Reference Committee that the Report of Reference Committee No I, Health and Education, be adopted as amended carried.



The Council on Scientific Activities and leadership from Florida's Colleges of Medicine meet annually at the Dean's Luncheon. Left to right: Robert C. Fore, Ed.D., Associate Executive Director Programs; R. G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.;* Orris O. Rollie, M.D., Chairman, Committee on Medical Education; Bernard J. Fogel, M.D., Dean, University of Miami School of Medicine; Luis M. Perez, M.D., President, Florida Medical Association; J. Lee Dockery, M.D., Associate Dean, University of Florida School of Medicine; James B. Perry, M.D., President-Elect, Florida Medical Association; Pierre J. Bouis Jr., M.D., Chairman, Council on Scientific Activities.

Spirit Dinner Cruise





2





4





6



7





9

At this year's Annual Meeting the FMA and Auxiliary sponsored a dinner cruise on The Spirit. (1) Dr. Luis M. Perez (2) Drs. Charles Hayes and Kay Hanley (3) Mrs. Jo Tignor (4) Mr. and Mrs. Donald C. Jones and Dr. and Mrs. James B. Perry (5) The Spirit (6) Dr. and Mrs. Rufus Broadaway (7) Dr. and Mrs. Frank Coleman (8) Dr. and Mrs. Milton Tignor (9) Drs. James Perry and James White.

Auxiliary Highlights





2







5



6



7





9

(1) Dr. and Mrs. Bruce Gerber. Mrs. Gerber received the Peggy Wilcox Award (2) Mr. Donald C. Jones, FMA Executive Vice President, addresses the Auxiliary House (3) Mrs. V.A. Marks, FMA-A President-Elect, addresses the FMA House (4) AMA President John J. Coury, M.D. and FMA-A President Mrs. Milton Tignor (5) Mrs. Gerber pins Mrs. Tignor with the Past President's Pin (6) Mrs. Marks and FMA President James B. Perry, M.D. (7) Mrs. Tignor addresses the FMA House of Delegates (8) Mrs. Tignor presents the President's Pin to Mrs. Marks (9) Seated: FMA President Luis M. Perez, M.D. and AMA Auxiliary President, Mrs. Mylie E. (Pat) Durham Jr. Standing: Mrs. Tignor.

Report of Reference Committee No. IV Legislation and Miscellaneous

Dr. Eberly called the Committee and members of Reference Committee No. IV, Legislation and Miscellaneous, to present their report.

Dr. T. Wallace Hahn, Chairman, and his Committee came forward to present the report of Reference Committee IV, Legislation and Miscellaneous.

The Committee commended Dr. Louis C. Murray for his continued outstanding work in his role as Chairman of the Council on Legislation. Furthermore, the Committee gave proper recognition and commendation to Thomas P. Wood, M.D., Chairman of the Committee on State Legislation; Mr. Donald S. Fraser Jr., Deputy Executive Director, Legislation and Public Affairs, George S. Palmer Jr., Assistant Director, Legislative Affairs; Ms. Lucy Mohs, Legislative Analyst; and to all other FMA staff members who have provided outstanding support of our legislative programs. The Committee also recognized the contributions of all members of the Florida Medical Association who have participated in FMA legislative activities during the past year.

Report of the Council on Legislation

The Reference Committee suggested that the AMA submit a report on national legislation in the same format used by the Florida Medical Association and in sufficient time for presentation at the 1987 Florida Medical Association Annual Meeting.

The motion of the Reference Committee that the report of the Council on Legislation be adopted carried.

Council on Legislation
Louis C. Murray, M.D., Chairman

Most of the work of the Council on Legislation is accomplished through activities of its two committees; the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation

This committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this committee have kept in close touch with their assigned senators and congressmen on the national legislative matters of interest to the FMA and American Medical Association.

The Association has maintained active liaison with members of the Florida Congressional delegation on key legislative issues. Conferences in Washington between FMA staff, key contact physicians and selected congressmen were necessary in order to carry out the FMA and AMA policies on these issues. In addition to individual visits, a comprehensive program of visitations was conducted by FMA key contact physicians and officers with the two U.S. Senators and House members who served on committees with jurisdiction over key health issues. This continuing personal liaison resulted in excellent cooperation from Florida's delegation.

The issues that necessitated major action by the FMA and contact physicians were:

- Opposition to an extension for one year of the freeze on actual fees charged Medicare beneficiaries by "non-participating physicians."
- Opposition to proposed freeze on direct graduate medical education costs.
- Support for establishment of an alternative means of resolving medical malpractice actions.
- Support for establishment of a Federal Vaccine Injury Compensation Program to compensate individuals who suffer certain injuries due to vaccines.
- Support for adoption of a "sunset" provision relating to health planning.
- Support for removal of the FTC's authority to preempt state laws relative to professional licensure or tasks professionals may perform.

The Ninety-ninth Congress continues to be increasingly active in federal health legislation. Among the key issues being considered of particular interest to the FMA are:

- Opposition to the expansion of the use of prospective payment and DRG system to specifically include hospital based physicians.
- Oppose efforts to impose further regulations on the practices of physicians in the hospital setting.
- Monitor efforts to modify malpractice laws at the federal legislative level.
- Opposition to proposed draft registration for physicians.

This will require the Association to continue to maintain close liaison with Florida's Congressional Delegation and with the AMA Washington Office.

Committee on State Legislation

The Committee on State Legislation has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Eight formal meetings of the Committee have been held along with the informal conference among Committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates, the Committee has worked closely with the Board of Governors in accomplishing our legislative objectives for the 1986 and 1985 sessions of the Florida Legislature.

The following items summarize the Committee's activities:

1. The legislative program is continuing to function under the supervision of Donald S. Fraser, Jr., Deputy Executive Director, Legislation and Public Affairs. He has been materially assisted by Ms. Lucy Mohs, Legislative Analyst and George S. Palmer, Jr., Assistant Director of Legislative Affairs. Particularly helpful to the legislative activity has been the FMA Field Offices. These have greatly increased the Association's ability to maintain liaison with county medical societies, contact physicians, specialty organizations and members of the Legislature.

2. The Capitol Dispensary. The Committee placed major emphasis on working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Linda Bass, R.N., head of the clinic, has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the "Doctor of the Day" Program.

3. The Committee on State Legislation. This Committee is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. In addition, priority attention has been directed toward increasing the role of the Auxiliary in the Association's efforts.

4. Publications. A legislative bulletin was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A listing of all bills monitored by the Capital Office is sent on a regular basis to county medical society executives and legislative chairmen. In addition, summaries and copies of key legislative proposals are distributed.

5. **1986 Legislative Accomplishments.** During the 1986 legislative session, there were more than 370 legislative proposals that required action by the Committee on State Legislation or the Capital Office. Matters of major interest to the Florida Medical Association were:

Tort Reform Legislation. In cooperation with the Florida Coalition for Liability Reform, the FMA played a key role in gaining enactment of a significant Tort and Insurance Reform package in the 1986 Session of the Florida Legislature. It is anticipated that this landmark package will bring stability to Florida's professional and commercial liability crisis.

Major components of the Act (CS/CS/SB 465) are:

Insurance Reforms:

- Rollback of liability rates by an annual rate of 40 percent on October 1, 1986, to January 1, 1987.
- Freeze on rate increases for the period of July 1, 1986, to January 1, 1987.
- Return of excess profits to policyholders.
- Rollback of liability rates (after January 1, 1987) to the 1984 rates, unless insurer can demonstrate need to go to higher levels.

Tort/Insurance Study

Creates a five-member task force to study tort and insurance law. The study is to determine the effect of the specific provisions in the bill plus other issues linked to reducing the costs of insurance, self-insurance and the tort/liability system. The study is also to ascertain if the 1988 Legislature needs to further address insurance rates and/or premiums. Interim report due prior to the 1987 Session. Final report due prior to 1988 Session.

Tort Reforms

- In civil actions for damages based on negligence, provides for proportional liability with respect to noneconomic damages, and proportional liability for economic damages with respect to defendants who are less at fault than the claimant.

Provides that defendants whose fault is equal to or more than that of the plaintiff are jointly and severally liable with respect to economic damages. Exemption for cases with total damages of less than $25,000, pollution cases, intentional torts and actions brought under RICO, environmental protection, anti-trust, land sales and securities fraud chapters; 1990 Sunset.

- In civil actions for damages, provides for a limitation of $450,000 on noneconomic damages. 1990 Sunset.

- In actions for personal injury or wrongful death, provides for structuring of future economic damages (economic losses) as to amounts exceeding $250,000. 1990 Sunset.

- In civil actions for damages, specifies that damages are to be itemized in verdicts.

- In civil actions for damages, requires the judge to reduce the judgment with respect to contributions from collateral sources. Provides that collateral source rule does not apply if subrogation right exists. Specifies that if subrogation applies, the provider of the collateral source must have deducted its equitable share for attorney's fees and costs.

- In civil actions for damages, provides protections against frivolous lawsuits through an offer of judgment/demand for judgment rule.

- In civil actions for damages, authorizes judges to require settlement conferences and specifies criteria by which a judge can increase or decrease a jury verdict through additur/remittitur.

- In civil actions where punitive damages are asserted, imposes pleading requirements for punitive damages of cases and provides for a limitation on punitive damages in certain types of cases equal to three times the amount of compensatory damages unless judge is presented with clear and convincing evidence that the jury award above that amount is not excessive. Forty percent of award to go to the plaintiff and 60 percent to go to the Public Medical Assistance Trust Fund (in wrongful death and personal injury cases) or to General Revenue (in other types of cases). 1990 Sunset on limitation.

Physician Financial Responsibility

The package provides relief from the mandatory medical malpractic law through the following options:

- **Full-time Physicians.** The physician in full-time practice can elect to not carry insurance but is required to pay any judgment within 60 days (up to $250,000 for those with hospital privileges and $100,000 for physicians without hospital privileges). The Board of Medical Examiners can take action against the physician, unless payment is made or unless satisfactory arrangement to pay, within financial ability of physician, is made.

- **Part-time Physician.** A physician can qualify for exemption as part-time or retired, provided: the physician has been in practice for the preceding 15 years, has no more than two paid claims exceeding $10,000 in the previous 5 years, and is confining practice to no more than 1,000 patient contact hours per year.

Issues Opposed by the Florida Medical Association Which Were Defeated In The 1986 Legislative Session

- Prohibition for physicians providing complimentary drug samples to their patients (HB 1332, SB 180)



Reference Committee No. IV (Legislation and Miscellaneous) was chaired by T. Wallace Hahn, M.D., Pompano Beach. Left to right: Helen Bradford, Recorder; James T. Cook III, M.D., Panama City; Larry P. Garrett, M.D., Ft. Myers; Paul T. Baroco, M.D, Pensacola; Joseph C. Von Thron, M.D,, Cocoa Beach; Wilbert L. Dawkins, M.D., Jacksonville; Sanford A. Mullen, M.D., Jacksonville; Charles A. Dunn, M.D., Miami.

- Assessment of $500 on physicians' license renewal fees to fund Medicaid.
- Prohibition of physicians referring patients or specimens to facilities in which they have a financial interest (HB 1074, SB 1187).
- Statutory codification of "Patient's Bill of Rights" (HB 1369, SB 686, SB 993).
- Reenactment of licensure of lay midwives (HB 597, SB 400).
- Authorization for dentists administering anesthesia in non-dental procedures.
- Mandated hospital staff privileges for non-physicians (HB 767).
- Authority for any blood donor to designate an individual to whom the donated blood shall be administered (HB 489, HB 576, SB 254).
- Licensure of homeopathic practitioners.
- Mandated benefits for services provided by ARNP's (HB 1385).
- Prohibition against the removal of corneal tissue from a decedent without permission of the next of kin (HB 116, HB 674).
- Exemptions to the Medical Practice Act to allow certain individuals to circumvent current licensing requirements (SB 1071, HB 866, SB 1087, HB 989).
- Authority for chiropractors and podiatrists to approve protocol for ARNP's and to provide supervision (HB 1352).
- Elimination of the requirement that the National Boards or FLEX must have been taken within 10 years immediately preceding application for licensure by endorsement (SB 1090).
- Requirement for supervising physicians be "physically present" and "immediately available" (HB 1395).
- Modification of Workers' Compensation three-member panel's consideration of prevailing charges in the community when establishing fee schedule (HB 893, SB 626).
- Authority for chiropractors to perform venipuncture (HB 1355).
- Specific appropriation to establish a school of chiropractic in Florida.
- Requirement for physicians to furnish information to a patient about his condition, treatment, lab reports and prognosis (SB 674).
- Authorization for local health councils to develop policy recommendations relating to health care ethical issues (SB 1139).
- Increase in licensing fees for hospitals, nursing homes, adult congregate living facilities, etc. (SB 584, SB 991).
- Mandated benefits for services provided by acupuncturists (HB 577, SB 679).
- Licensure and regulation of dieticians (HB 254, SB 786).
- Prohibition of termination of pregnancy of unmarried minor unless notice given to both parents (HB 80).
- Requirement for physician performing an abortion to inform the woman that an anesthetic is available for the fetus to alleviate pain (HB 312).
- Authorization for basic X-ray machine operators to work in HMO's (HB 530).
- Creation of an independent board to regulate physical therapists.
- Attempts to weaken the requirement for physician supervision of ARNP's as provided in the Nurse Practice Act (HB 1352).
- Expansion of the Certificate of Need Program to include equipment in a physician's office.

Issues On Which The Florida Medical Association's Position Was Sustained:

- Support for a physician of record be required for approving, disapproving or modifying a treatment plan developed by a physical therapist (CS/SB 848).
- Support for the statutory designation of the State Health Officer (HB 1317).
- Support for mandating insurance coverage of health maintenance examinations and activities for children (SB 460).

- Support for confidentiality of physicians and patients contained in medical incident reports submitted to Department of Health and Rehabilitative Services (HB 1383).
- Support of legislation to authorize public health nurses dispensing medicine in county public health units with protocol (CS/SB 858).
- Support for requiring seat belts to be worn by vehicle drivers and front seat passengers (HB 40).
- Support for a Statewide Organ Transplant Advisory Council (HB 628).
- Opposition to veto override of decertification of treatment by chiropractors in automobile personal injury cases.
- Opposition to veto override of the Motorcycle Helmet Law.

Issues On Which The Florida Medical Association's Positions Were Not Sustained:

- Support for legislation relating to health care for the indigent funded by a broad-based source.
- Support for legislation expanding the list of notifiable occupational diseases.
- Support for strengthened verification system for trauma centers.
- Support for abolishment of the Certificate of Need Program.
- Opposition to veto override of mandatory insurance benefits for chiropractic coverage.

Other Health Legislation Passed By The Legislature:

- Requires Department of Health and Rehabilitative Services to establish an outcome evaluation program to review Children, Youth and Family Services (HB 28).
- Authorizes counties to create Juvenile Welfare Boards to maintain child guidance and psychiatric clinics through the levy of an additional property tax (HB 55).
- Requires Department of Professional Regulation boards to adopt, by rule, disciplinary guidelines that specify a range of designated penalties based on severity of the offense (HB 123).
- Requires Department of Professional Regulation to suspend the license of health care professionals who are convicted of a felony charge under drug abuse or controlled substances laws (HB 144).
- Requires medical examiner to notify the appropriate law enforcement agency upon receipt of an unidentified body (HB 154).
- Reenacts licensure and regulation of persons practicing acupuncture (HB 558).
- Amends Part V of Chapter 468 to create "respiratory care practitioners" and authorizes respiratory care therapists who have passed a national registry exam to use the abbreviation "RRT" (HB 624).
- Requires hospitals to consider applications from ARNP's for clinical privileges (HB 767).
- Increases fine for violations relating to false advertising and claims that drugs have on specific disorders (HB 805).
- Requires certain individuals to ask next of kin or representative for tissue or organs of deceased patient (HB 813).
- Requires certification exam of respiratory therapy technicians to be offered in English and Spanish (HB 1166).
- Provides public campaign financing for candidates for Governor or Cabinet (HB 1194).
- Amends Section 945.48, Florida Statutes, relating to rights of inmates in mental health treatment facilities (HB 1320).
- Reenacts regulation by Department of Professional Regulation of the fitting and dispensing of hearing aids (HB 1342).
- Reenacts regulation and licensing of nurses (HB 1352).
- Provides for the future "sunset" of abortion clinics, HMOs and other section of Florida Statutes (HB 1366).
- Amendments to the 1985 Medical Malpractice bill to resolve several technical problems; known as the Malpractice "Glitch" bill (HB 1383).
- Requires individuals engaged in the manufacture, distribution, selling or transportation of acetone or ether to annually register with Department of Law Enforcement (SB 101).
- Authorizes candidates or political committees to make gifts of money in lieu of flowers in memory of a deceased person (SB 129).
- Reenacts statute regulating acupuncture clinics (SB 178).
- Provides confidentiality of patient medical records and medical claims records of state employees who subscribe to the State Employees Group Health Self-Insurance Plan (SB 353).
- Reenacts Chapter 461 regulating and licensing podiatrists (SB 399).
- Allows physicians and dentists who have been EMT's and who have passed an exam to be certified as a paramedic (SB 422).
- Amends Section 442.102 to provide regulations relating to toxic substances in the workplace do not apply to certain items which do not result in exposure to a toxic substance under normal use (SB 582).
- Reenacts Chapter 486 relating to the licensing and regulation of Physical Therapists (SB 848).
- Reenacts Chapter 484 relating to the licensing and regulation of opticians (SB 894).
- Requires hospitals with full-time emergency rooms to admit persons who require emergency care if a hospital physician determines they should be admitted (SB 1036).
- Establishes an Impaired Practitioners Committee to establish guidelines for approving drug or alcohol abuse treatment programs for health professionals (SB 1155).

Items Contained In HB 1381, The General Appropriations Bill, Of Interest To The Florida Medical Association:

- Appropriation of $5,913,802 from General Revenue Fund to continue the Community Hospital Education Program (compared to $5,521,814 in 1985).
- Appropriation of $9,843,699 from General Revenue Fund ($7,805,693) and maternal and Child Health Block Trust Fund

($2,538,006) for Improved Pregnancy Outcome Program (compared to $7,343,699 in 1985).

- Appropriation of $1,208,000 from General Revenue fund for 302 students at the Southeastern College of Osteopathic Medicine (compared to $1,080,000 for 270 students in 1985).

- Appropriation of $1,244,285 from General Revenue Fund to Department of Health and Rehabilitative Services for the renovation and equipping of an inpatient and outpatient clinic for AIDS patients at Jackson Memorial Hospital in Miami.

- Appropriation up to $100,000 to be used to contract with the Florida Medical Foundation, Inc. for the purpose of providing consulting services for the Impaired Professionals Program.

Because of the inability of the Legislature to reenact the Medical Practice Act, Optometric Practice Act, Florida Pharmacy Act, Osteopathic Practice Act and Dental Practice Act, a Special Session has been scheduled for June 19, 1986. A Supplemental Board Report will be submitted detailing the disposition of these issues of concern to medicine.

6. **1985 Legislative Accomplishments.** The inclusion of results from the 1985 Legislative Session in this Annual Report is a result of the timetable for submitting information at the 1985 FMA Annual Meeting. The 1985 Legislative Session had not adjourned by the convening of the 1985 Annual Meeting; therefore, this Annual Report combines the final results of both the 1985 and the 1986 Legislative Sessions.

During the 1985 Legislative Session, there were more than 280 legislative proposals that required action by the Committee on State Legislation or the Capital Office staff. Matters of major interest to the Florida Medical Association in 1985 were:

Professional Liability Legislation

In an effort to improve the current tort system and provide some relief to the medical malpractice crisis in Florida, the Legislature passed HB 1352, the Comprehensive Medical Malpractice Reform Act of 1985, which includes:

- A community standard of care which will allow juries to consider all relevant circumstances surrounding an alleged action of malpractice.

- Structured payments on all future damages above $500,000.

- Increased protection for peer review activities.

- A new offer of judgment statute which should help encourage settlements.

- A new 90-day cooling off statute, coupled with non-binding arbitration when appropriate.

- A sliding scale for lawyers' contingency fees.

- A study of risk management programs to determine what effect they have on medical malpractice claims.

- Mandatory professional liability insurance as a condition for licensure effective January 1, 1987.

Issues Opposed by the Florida Medical Association Which Were Defeated in the 1985 Legislative Session:

- Requirements for hospitals to grant staff privileges to non-physicians (SB 303,304). The Legislature tracked the FMA Council on Legislation's recommendation and required hospitals to establish rules and procedures for consideration of an application for clinical privileges of nurse anesthetists and psychologists.

- Exemptions from the Educational Commission for Foreign Medical Graduates' examination and certificate requirements for licensure of foreign medical graduates (CS/HB 1323). While these exemptions were not adopted, the 1985 Legislature provided a limited exemption from the approved clinical training requirements for medical licensure of certain foreign medical graduates.

- Mandatory health insurance coverage for ARNPs, psychologists and nurse anesthetists (SB 305, SB 836, HB 518, HB 868).

- Reenactment of the licensure law for lay midwives (SB 1220/HB 991).

- Certificate of Need requirements for equipment exceeding $1 million in physicians' offices (SB 929/HB 1391).

- Increase in physicians' licenses renewal fees as a method of increasing Medicaid reimbursement fees for physicians' services (HB 272, SB 328).

- Reform of campaign financing legislation deleting the authority to contribute to unopposing candidates in primary elections, reducing contribution limits and imposing aggregate limits for political action committees (SB 46, SB 168).

- Authorization for dentist to administer nondental general anesthesia if such individuals have completed a residency in anesthesiology at a medical school approved by the State Board of Medical Examiners (SB 1045).

- A requirement for certain health care facilities to keep records regarding surgeons performance on elective surgery (SB 580).

- Establishment of Exclusive Provider Organization, or "lockout" provisions in insurance contracts marketed in Florida. The FMA was successful in keeping this legislation from surfacing during the 1985 Session.

- A requirement that a physician who performs an abortion must inform the mother that drugs are available to alleviate the pain to the fetus (HB 253).

- Prohibition of the termination of pregnancy of an unmarried minor unless actual notice is given to both parents or the legal guardian of the pregnant minor (HB 364.).

- Authorizations for the use of drugs by optometrists. This legislation did not surface during the 1985 Session.

- Authorization for an individual blood donor to designate who they want the blood to be given to as well as a prohibition against a blood bank, hospital, etc., from taking blood from certain people (SB 586).

- Appointment of a health advocate, who must be an attorney, to represent the general public in all matters relating to the providing of services in Florida (SB 369).

- A requirement for mandatory second opinions prior to elective surgery for coverage under the state group health insurance plan (SB 467/HB 145).

- Authorization for use of pitocin to augment labor in birthing centers (HB 854).

Issues On Which the Florida Medical Association's Position Was Sustained:

- Support of the creation of the Alzheimer's Disease Advisory Committee located within the Department of Health and

Rehabilitative Services. The Department may award research grants to qualified profit or nonprofit associations for development of programs in the control, prevention, training and research of Alzheimer's Disease. The bill also provides for memory disorder clinics and respite care programs (CS/CS/HB 77).

The FMA Auxiliary was instrumental in getting the Senate version of the bill aligned with the House bill, which has a corresponding appropriation of $500,000. The efforts of the Auxiliary helped to ensure the passage of this timely legislation.

- Creation of the "Clean Indoor Air Act" which designates areas in public places and at public meetings that are reasonably free from the effects of tobacco smoke (CS/HB 2811).

- Support of legislation that raises the state's legal drinking age from 19 to 21 (CS/SB 1).

- Support for a joint legislative review of the policies, duties and responsibilities of the Department of Health and Rehabilitative Services to develop a specific plan for reorganization of the Department during the 1986 Regular Session (HB 1427).

- Support of legislation that reenacted the practice of naturopathy without providing for the further licensing of naturopathic practice (SB 246).

- Support of the prohibition against the prescribing, administering or supplying of growth hormones for the purpose of musclebuilding or enhancing athletic performance (HB 33).

- Support of quality of care and grievance proceeding requirements for Health Maintenance Organizations (HB 1387).

Issues on Which the Florida Medical Association's Positions Were Not Sustained:

- Support of provisions of the establishment of regionally designated hospitals with emergency facilities as trauma centers (HB 1003).

- Support of certification and evaluation of foreign medical schools by the Department of Professional Regulation or an agency appointed by the Department (HB 1217, HB 1352).

- Support of requirement for health insurance policies and health care services plans to provide coverage for children's health supervision services until they are 21 (HB 1031/SB 948).

- Support of establishment of criteria to be considered by the Legislature when considering enacting laws to regulate a previously unregulated profession (SB 1029).

- Support of a prohibition against persons being held liable in civil damages for any act or omission that results in a person being born alive instead of being aborted (SB 254/HB 207).

- Support of a requirement that operators of a private passenger motor vehicle and the front seat passengers must wear properly adjusted and fastened seat belts (CS/HB 37, 47, 70).

- Opposition to pharmacists to prescribe certain drugs contained on a formulary (HB 392).

- Opposition to licensure exemptions to allow certain individuals to practice medicine in Florida without meeting the normal licensure requirements (CS/HB 1132).

- Opposition to creation of a limited license to practice medicine in Florida for persons who are designated as "distinguished scholars" and serve as full-time faculty members at a Florida medical school (CS/SB 340).

Other Health Legislation Passed by the Legislature:

- Requirement for hospitals to notify within 72 hours any emergency medical technician, paramedic or other person having direct contact with a patient being transported to the hospital if the patient is found to have an infectious disease (CS/HB 627).

- Provision for a limited exemption from the approved clinical training requirements for medical licensure of certain foreign medical graduates (CS/SB 783).

- Readoption of Chapters 476 and 477, Florida Statutes, relating to barbering and cosmetology (CS/SB 218).

- Readoption of Chapter 474, Florida Statutes, relating to veterinary medical practice (CS/SB 91).

- Provision that a licensed pharmacist may fill or refill a valid prescription which is on file in a pharmacy located in Florida and has been transferred from one pharmacy to another by means, including by way of electronic data processing equipment (HB 266).

- Provision that records maintained in a pharmacy related to the filling of prescriptions and the dispensing of medicinal drugs shall not be furnished to anyone except the patient for whom the drugs were prescribed except as authorized by state law (HB 395).

- Creation of the procedure for handling reports relating to the impairment of a podiatrist by drugs or alcohol (HB 1218).

- Amendment to Chapter 480, Florida Statutes, relating to the practice of massage, to add the definition of colonic irrigation as part of massage practice (HB 1254).

- Requirement that each licensed nursing home is directed to file an annual cost report with the Hospital Cost Containment Board which analyzes the data and reports its findings to the Legislature (CS/CS/SB 235).

- Provision for the appointment of an Assistant Secretary for Health Services in the Department of Corrections to develop systems for health care programs and professional health care staff in the state corrections system (CS/SB 498).

- Conforming Florida's Schedule of Controlled Substances to the recent changes made to the Federal Schedule of Controlled Substances by adding alfentanil and 3-methylfentanyl to Schedule I, and by removing sufentantil from Schedule I and adding it to Schedule II (CS/SB 618).

- Making it a felony to manufacture, distribute or sell imitation controlled substances (drugs) to anyone under the age of 18 (SB 696).

- Provision for the licensure and regulation of alcohol prevention and treatment programs and facilities by the Department of Health and Rehabilitative Services (CS/SB 755).

- Authorization for the Secretary of the Department of Health and Rehabilitative Services to declare that a threat to the public exists when a disease such as Acquired Immune Deficiency Syndrome (AIDS) occurs in Florida (SB 1038).

- Requires health care providers who advertise a discounted or reduced fee to state in such ad that the patient has the right to refuse to pay for any other service performed as a result of and within 72 hours of responding to the advertisement for the

discounted or reduced fee service or treatment (HB 100).

- Makes it a first degree misdemeanor to sell or otherwise deliver without a presciption to anyone under 18 years of age any hypodermic syringe, needle or other object which may be used to inject substances into the human body (HB 134).

- Adds spina bifida to the definition of developmental disabilities in Chapter 393, Florida Statutes (HB 169).

- Requires that a minor under the age of 14 admitted to any public or private hospital be separated from adults and not be placed in a bed, room or ward with adults (HB 171).

- Provides that the Department of Professional Regulation rather than the Department of Health and Rehabilitative Services shall adopt rules and standards for the fitting and dispensing of hearing aids (CS/HB 421).
- Provides that if an examination, investigation or autopsy is performed by the district medical examiner upon the body of a person who died while in the custody of a state facility or institution, that state agency shall pay for such services and any costs of transporting the body to the medical examiner (HB 617).

- Prohibits the sale of tobacco products and cigarette wrappers to minors. Defines "cigarette" to include clove cigarettes and tobacco substitutes. (CS/HB 664).

- Reinstates Chapter 514, Florida Statutes, the regulation of swimming pools, by the Department of Health and Rehabilitative Services (HB 1319).

- Establishment of a program of regional perinatal intensive care centers (RPICC's) for critically ill newborns and their mothers throughout the state.

- Requires direct payment of hospital and medical services to designated providers when an insured specifically authorizes such payment in any health insurance claims form (HB 740).

- Deletes persons and facilities regulated under Chapter 465, Florida Statutes, the Florida Pharmacy Act, from the definition of "licensed health care providers" and, therefore, allows insurance companies to contract with these providers for alternative rates of payment (SB 427).

- Requires the Department of Health and Rehabilitative Services, with the concurrence of the Department of Highway Safety and Motor Vehicles, to develop a continuing program to educate and inform doctors, law enforcement agencies and the public on state laws and the need for anatomical gifts.

The following appropriations of interest to medicine were included in SB 1300:

- Appropriation of $5,521,814 from General Revenue Fund to continue the Community Hospital Education Program (compared to $5,291,440 in 1984).

- Appropriation of $7,343,699 from General Revenue Fund ($4,805,693) and from Maternal and Child Health Block Trust Fund ($2,538,006) for Improved Pregnancy Outcome Program (compared to $5,188,223 in 1984).

- Appropriation of $1,080,000 from General Revenue Fund for 270 students at the Southeastern College of Osteopathic Medicine (compared to $800,000 for 200 students in 1984).

Issues Vetoed by Governor Bob Graham:

Governor Bob Graham exercised his veto authority by withholding approval of these bills and a portion of the 1985-86 budget that passed the 1985 Legislature.

- Appropriation of $75,000 from General Revenue Fund for a college of chiropractic in Florida (compared to $150,000 in 1984).

- Chiropractic Insurance (HB 170) — Provides for mandatory insurance coverage for chiropractic services or procedures performed within the scope of a chiropractor's practice.

- Motor Vehicle Insurance Insurance (HB 710) — Prohibits an insurer from withdrawing payment to a treating physician under personal injury protection (PIP) coverage without the consent of the injured person unless the insurer obtains a report from a like practitioner stating the treatment was unnecessary. That is, only a medical physician could evaluate a patient treated by another medical physician, only a chiropractor could evaluate a patient treated by another chiropractor, etc.

- Motorcycle Helmets (HB 647) — Exempts persons 21 years old or older from wearing protective headgear or eye-protective devices when operating or riding a motorcycle.

Report D of the Board of Governors

The Reference Committee commended publicly members of the Florida Medical Association Board of Governors for their tireless assistance in achieving the Association's legislative objectives. In particular, Luis M. Perez, M.D., Florida Medical Association President, was commended for his outstanding leadership and unselfish contributions to the well-being of the Association.

The motion of the Reference Committee to adopt Report D of the Board of Governors carried.

Report D of the Board of Governors

Luis M. Perez, M.D., Chairman

The Annual Reports on the major activities of the Council on Legislation and FLAMPAC are included in this section of the Delegate's Handbook. The Board has carefully reviewed the activities of the Council and FLAMPAC during the past Association year and the Council's recommendations regarding important legislative issues to be addressed during the 1986 Session of the Florida Legislature. The House of Delegates at its interim meeting in January 1986 acted on the major issues that were to be addressed during the 1986 legislative session.

COUNCIL ON LEGISLATION

1985 Legislative Session: At its June 1985 meeting, the Board of Governors received an extensive report in respect to the results of the 1985 legislative session. During that session, over 280 different legislative proposals involving health issues were considered. The most extensive and time-consuming issue continued to be the professional liability issue. During the 1985 session, the Legislature adopted House Bill 1352 entitled "The Comprehensive Medical Malpractice Reform Act of 1985." Both the Executive Committee and the Board received an extensive review of this legislation.

FMA 1986 Legislative Proposals: At its October 1985 meeting, the Board considered several important legislative issues that would be addressed during the 1986 legislative session. The Board specifically adopted the following tort reform proposals in respect to the professional liability crisis:

- Elimination of the Doctrine of Joint and Several Liability;
- Capping noneconomic damages;
- Opposing the requirement of professional liability insurance as a condition of licensure.

The Board also directed that the FMA delegation to the American Medical Association introduce a resolution at the AMA Interim Meeting in December of 1985 calling on the AMA to place the highest priority on the resolution of the professional liability crisis.

In addition to these issues, the Board approved support of the concept, in respect to the professional liability issue, of pursuing a contract mechanism requiring a breach of the standard of care in order to trigger payments in accordance with a workers' compensation style benefit schedule for the resolution of medical malpractice disputes as a legislative objective for 1987.

Indigent Health Care: During the October meeting, the Board also took positions on the indigent health care issue and adopted the policy that the Florida Medical Association seek through legislative means adequate funding for indigent and medically indigent health care through a broad-based revenue funding source.

The Board further approved the policy that the services provided to the indigent and medically indigent be delivered through a coordinated public and private sector provider system that includes independent practitioners providing an emphasis on primary care and preventive medicine.

Foreign Medical Graduates: In respect to foreign medical graduates, which the Board understood to be a key issue during the 1986 session, the Board approved the policy position on this matter that would require the Association to coordinate with the Department of Professional Regulations the development of legislative support for a proposal to insure that all individuals applying for and taking the medical licensure examination in Florida have met the same educational standards and training requirements necessary to practice medicine in the State.

Encroachment: The Board further re-affirmed a continuing policy position to opposing entrepreneurial entities and all health care practitioner activities as they relate to the encroachment of the practice of medicine.

Health Issues: At the February 1986 meeting, the Board considered additional recommendations from the Council on Legislation to be implemented prior to the 1986 Legislative Session. The Board adopted the following key recommendations:

- Continue support for the Association's request for an appropriate increase for all health professionals in reimbursement under Medicaid;
- Opposition to any attempt to restrict or prohibit the distribution of drug samples by physicians to patients;
- Opposition to the prohibition against physicians' dispensing medicines from their office;
- Opposition to legislation that would mandate hospital staff privileges for optometrists;
- Support for amendments to existing law to provide for confidentiality of patient and physician identification in respect to incident reports;
- Opposition to any expansion of the scope of activities of physicians' assistants beyond the current law.

FMA 1986 Interim Meeting: During the 1986 Interim Meeting of the House of Delegates, the House of Delegates took up several key legislative issues that would become FMA's 1986 legislative priorities. The recommendations from the Board of Governors that were adopted by the House of Delegates included recommendations concerning the Association's professional liability program with the key emphasis on placing a cap on general damages. Additional recommendations by the Board that were adopted by the House included extensive recommendations in respect to the sunset of the Medical Practice Act and other allied health professional practice acts. Additionally, the House of Delegates adopted recommendations of the Board of Governors in respect to the certificate of need, trauma centers, indigent health care, and re-organization of the Department of Health and Rehabilitative Services.

1986 Session: During the 1986 Session, tort reform and insurance reform dominated the session. Dr. Perez and Dr. Perry, on behalf of the Board of Governors, along with Dr. Murray, Chairman of the Council on Legislation, members of the Committee on State Legislation; spent extensive time in Tallahassee personally meeting with legislators and key committee staff in order to promote the policies adopted by the House of Delegates in respect to the key legislative issues. More than 370 legislative proposals required attention from the FMA Committee on State Legislation and the FMA Capital Office staff.

Florida Coalition for Liability Reform (FCLR): The key to the success of the final adoption of the tort reform legislation was the role played by the Florida Coalition for Liability Reform. This effort was initiated through the policy direction of the Board of Governors and spearheaded by the President of the FMA, Dr. Luis Perez, who acted as the Vice Chairman of the Coalition. For the first time in the history of Florida, significant tort reforms were adopted by the Legislature to include:

- $450,000 cap on noneconomic damages;
- Significant modification of the Doctrine of Joint and Several Liability;
- Structuring of future economic damages exceeding $250,000;
- Significant modification in the area of punitive damages.

In addition, the tort reform and insurance package included significant modification of the mandatory medical malpractice insurance requirements. A complete report on all of the health issues acted on by the Legislature is summarized in the Annual Report of the Council on Legislation included in the Delegates' Handbook.

The Board took the following actions regarding additional recommendations from the Council:

AARP Liaison: The Board authorized the FMA to seek the establishment of a list of FMA members qualified to speak on subjects of interest and benefit to the members of the AARP in the hope of enhancing the liaison with Florida's elderly population.

County Medical Society Legislative Chairmen: The Board concurred with the Council that an invitation be extended to county medical society legislative chairmen to attend meetings of the Council on Legislation. It was felt that this would help foster a better understanding and appreciation for the procedure by which the Association's legislative policy is developed. In addition, such participation would provide county medical society legislative chairmen an opportunity to update their respective county societies in an expeditious manner.

Overview of Legislative Activity: In 1985 and 1986, professional liability/tort reform dominated the activity of the Florida Medical Association on the legislative front. The Board of Governors, reacting to the concerns of physicians in the state of Florida, has kept these issues at the top of the FMA's legislative priorities. The Board continues to recognize that much is left to be done in the area of resolving the professional liability crisis and ultimately reducing the enormous and outrageous premiums that physicians are required to pay for professional liability protection. The Board of Govemors continues to review the entire legislative program mechanism looking for ways to improve our legislative and political education efforts. A review of the 1986 won/loss legislative record is revealing from the standpoint of the overall success of the Florida Medical Association. This success must be tempered by our continuing efforts to totally eradicate the professional liability problem. During the 1986 Legislative Session, while so much time

and energy of the Board of Governors was directed toward the tort reform issues, many other important issues required extensive attention. Other issues consumed a great deal of the time, talent and energy of the medical community. As the Florida Medical Association enters a new Association year, the Board of Governors is mindful that without a continuing increase in the involvement of physicians and spouses, the Association in the future will not be able to claim the many successes that have been achieved in the past. The presence of an overwhelming number of important medical issues in the legislative arena require substantial support from the medical community at the "grass roots" level and further involvement and follow up with members of the Legislature during the legislative session. Members of the FMA-Auxiliary, county medical societies and specialty groups have responded to the call for this type of effort in an admirable way. Their combined efforts during 1986 were exemplary and contributed significantly to our success. While the Board of Governors will continue to seek to implement the policies of the House of Delegates in the legislative area, it will also seek to involve each member of the Association and their spouse in these important matters.

FLAMPAC

Activities: The Board received reports regarding the current activities of FLAMPAC, which included information on the 1986 elections, with the major objective of developing additional legislative support for the FMA's tort reform professional liability objectives. The election criteria to achieve these goals is being established.

Membership: The Board received an informational report in respect to FLAMPAC membership which indicated current membership at 4,853. It was further noted in the report that the FLAMPAC Board of Directors had approved a dues change that deleted the $25 dues category for "non-physicians." As a result of this change, auxilians and other non-M.D. members must join at either the regular ($50 per year) or sustaining ($100 per year) dues level.

Board of Directors: The Board of Governors approved the appointment of the following individuals to the FLAMPAC Board of Directors for 1986:

19 from Congressional Districts

1 William W. Thompson, M.D.
2 Terence P. McCoy, M.D.
3 Mrs. James H. Corwin
4 James G. White, M.D.
5 Louis C. Murray, M.D.
6 Frank R. Wilkerson Jr., M.D.
7 Frank C. Coleman, M.D.
8 James L. West, M.D.
9 Donald G. Nikolaus, M.D.
10 John W. Glotfelty, M.D.
11 Brian P. Gibbons, M.D.
12 Donald L. Ames, M.D.
13 Robert E. Windom, M.D.
14 Dick L. Van Eldik, M.D.
15 T. W. Hahn, M.D.
16 Stanley Margulies, M.D.
17 James W. Bridges, M.D.
18 Margaret Skinner, M.D.
19 Warren Lindau, M.D.

3 from FMA Auxiliary

Mrs. B. David Epstein
Mrs. Arthur L. Eberly
Mrs. Donald G. Nikolaus

2 from FMA Board of Governors

Luis M. Perez, M.D.
Kay K. Hanley, M.D.

2 from Committee on State Legislation

Thomas M. Daniel, M.D.
Michael J. Pickering, M.D.

6 from State At-Large

H. Quillian Jones Jr., M.D.
R. Benjamin Moore, M.D.
Carlos G. Llanes, M.D.
Juan A. Wester, M.D.
Alvin E. Smith, M.D.
Richard S. Hodes, M.D.

FLAMPAC Officers

Officers for FLAMPAC for 1986 included the following:
President — Robert E. Windom, M.D.
Vice President — James G. White, M.D.
Secretary — Carlos G. Llanes, M.D.
Treasurer — Louis C. Murray, M.D.
Assistant Treasurer — Donald C. Jones

Report F
of the
Board of Governors
1985 House of Delegates Referrals

The motion of the Reference Committee to adopt Resolution 85-12, Limitations to Medical Malpractice Liability, Dade County Medical Association, carried.

The motion of the Reference Committee to adopt Resolution 85-19, SBME Licensure Renewal Procedure, Polk County Medical Association, carried.

The motion of the Reference Committee to adopt Resolution 85-24, Medical Licensure, Duval County Medical Society, carried.

The motion of the Reference Committee to adopt Resolution 85-25, HMO Financial Responsibility, FMA Council on Hospital Medical Staffs, carried.

RESOLUTION 86A-15
Not-for-Profit Liability
Dade County Medical Association

The motion of the Reference Committee that Resolution 86A-15 be referred to the Board of Governors for study and implementation carried.

RESOLUTION 86A-15

Not-for-Profit Liability

(Referred to Board of Governors)

Whereas, liability insurance premiums continue to escalate for all corporations; and

Whereas, the premium escalation holds true for not-for-profit corporations, including associations; and

Whereas, the Florida Medical Association and its component county medical associations are faced with a premium and availability crisis in securing suitable liability protection; and

Whereas, medical associations, like most not-for-profit organizations, do not have the financial ability to absorb these escalating premium increases; and

Whereas, directors for not-for-profit corporations typically serve on a voluntary, uncompensated basis; therefore be it

RESOLVED, That the Florida Medical Association place as a goal for its 1987 Legislative Program, the enactment of legislation patterned after other state statutes which, by use of Good Samaritan or other statutes, provides exemptions from liability to not-for-profit professional associations and their directors and officers.

RESOLUTION 86A-16
Sales Tax Exemption
Dade County Medical Association

The motion from the floor to refer 86A-16 to the Board of Governors carried.

RESOLUTION 86A-16

Sales Tax Exemption

(Referred to Board of Governors)

Whereas, the need for quality health care is vital to the citizens of Florida; and

Whereas, health care costs have risen dramatically over the last few years; and

Whereas, the imposition of a sales tax on professional medical services would be harmful to the citizens of the state; therefore be it

RESOLVED, That any consideration of the imposition of a sales tax on professional services of physicians in Florida be aggressively opposed by the Florida Medical Association.

RESOLUTION 86A-18
Sample Medications
Dade County Medical Association

The motion of the Reference Committee to delete lines 19-21, and on line 25 strike the period and insert after the word "States" "because existing laws are adequate to prevent misuse" carried.

Resolution 86A-18 was adopted as amended.

RESOLUTION 86A-18

Sample Medications

RESOLVED, That the FMA Delegation to the American Medical Association introduce a resolution directing the AMA to aggressively oppose any federal legislation that would in any way limit the use of sample medications by the physicians of the United States because existing laws are adequate to prevent misuse.

RESOLUTION 86A-19
Rally in Washington, D.C.
Dade County Medical Association

The motion of the Reference Committee to delete on line 14 after the word "States" the semicolon, insert a period and delete "and be it further resolved" and delete lines 15-18 carried. The amended resolve read as follows:

RESOLVED, That the Florida Medical Association petition the American Medical Association to organize and coordinate a mass rally and legislative meeting of its nationwide membership, and other interested parties, in Washington, D.C., in 1987 to influence passage favorable of tort reform legislation before the Congress of the United States.

Resolution 86A-19 was adopted as amended.

RESOLUTION 86A-19

Rally in Washington, D.C.

RESOLVED, That the Florida Medical Association petition the American Medical Association to organize and coordinate a mass rally and legislative meeting of its nationwide membership, and other interested parties, in Washington, D.C., in 1987 to influence passage favorable of tort reform legislation before the Congress of the United States.

RESOLUTION 86A-20
Contingency of Patient Compensation Law
Dade County Medical Association

The motion of the Reference Committee to insert on line 16 after the word "awards," insert "because it has been reliably estimated that about 28 cents out of every dollar paid in premiums really get to the injured patient and about 60 cents for legal fees, and that the fee schedule be," on line 19 delete "(a)" and insert "$50,000," and on line 21 delete "(b)" and insert "$100,000" carried.

The motion from the floor to refer the amended Resolution 86A-20 to the Board of Governors for implementation carried.

RESOLUTION 86A-20

Contingency Patient Compensation Law

(Referred to Board of Governors)

Whereas, the cost of professional liability insurance is creating a so-called "malpractice crisis"; and

Whereas, the main reason for carrying professional liability insurance is to provide protection for economic losses of patients who may be injured during the course of treatment, including surgery; and

Whereas, it has been estimated that only about 28 cents out of every dollar paid in premiums really get to the injured patient and about 60 cents go for legal fees; and

Whereas, awards made by juries are intended to compensate primarily the injured parties and not the legal profession; and

Whereas, it is the duty of the Florida Medical Association to see that injured patients are properly compensated for results of malpractice (not maloccurrences) on the part of Florida physicians; therefore be it

RESOLVED, That the Florida Medical Association add to its legislative goals that of promoting a law to guarantee a "contingency patient compensation" for injured patients who win jury awards because it has been reliably estimated that about 28 cents out of every dollar paid in premiums really get to the injured patient and about 60 cents for legal fees, and that the fee schedule be based on a graduated scale which will channel most of the award to the plaintiff such as follows:

a) If the award is $50,000 or less — 60% should go to the injured patient;
b) If the award is greater than $50,000, 67% any amount from $50,000 to $100,000 should go to the injured patient;
c) If the award is greater than $100,000, 75% of any amount from $100,000 to $200,000 should go to the injured patient;
d) If the award is over $200,000, 90% of any amount over this should go to the injured patient;
e) It is understood that all legal costs will be treated as has been the custom previously.

RESOLUTION 86A-21
Mediation Panels
Dade County Medical Association

Resolution 86A-21 was adopted.

RESOLUTION 86A-21

Mediation Panels

RESOLVED, That the Florida Medical Association aggressively pursue all legislative and/or constitutional paths to the reinstatement of mediation panels.

RESOLUTION 86A-22
HMO Physician Liability Insurance Coverage
Dade County Medical Association

Resolution 86A-22 was not adopted.

RESOLUTION 86A-23
Education and Licensure
Dade County Medical Association

Resolution 86A-23 was adopted.

RESOLUTION 86A-23

Education and Licensure

RESOLVED, That the Florida Medical Association support the efforts of the State Board of Medical Examiners in upholding the standards of licensure; and be it further

RESOLVED, That the Florida Medical Association encourage the Florida Legislature to provide that requirements for licensure include adequate premedical education, a medical school curriculum deemed adequate in duration, and in course content, and include at least one year of appropriate postgraduate training.

RESOLUTION 86A-24
Licensure and Assignment
Dade County Medical Association

Resolution 86A-24 was adopted.

RESOLUTION 86A-24

Licensure and Assignment

RESOLVED, That the Florida Medical Association actively oppose any effort by the Florida Legislature to mandate acceptance of any third-party payor assignment as a condition of licensure; and be it further

RESOLVED, That the Florida Medical Association take all steps necessary to be prepared to challenge the authority of the Florida Legislature to enact legislation tying licensure to acceptance of assignment.

RESOLUTION 86A-25
Health Insurance Requirements
Dade County Medical Association

The motion of the Reference Committee that changes be made to the resolution: on line 13 delete the word "mandate" and insert "require;" on line 15 delete the word "traditional;" on line 15 delete the words "at equivalent," line 16, and through the word "programs" on line 17 carried.

The amended resolve read as follows:

RESOLVED, That the Florida Medical Association immediately prepare to introduce legislation in the Florida Legislature that will require that all employers offering health benefit plans to their employees also include medical insurance covering fee-for-service medical care; and be it further

RESOLVED, That the Florida Medical Association, should such legislation be introduced, mount a statewide campaign to ensure passage of this legislation by educating the public and obtaining public support; and be it further

RESOLVED, That the American Medical Association seek the introduction of similar legislation in the U.S. Congress.

Resolution 86A-25 was adopted as amended.

RESOLUTION 86A-25

Health Insurance Requirements

RESOLVED, That the Florida Medical Association immediately prepare to introduce legislation in the Florida Legislature that will require that all employers offering health benefit plans to their employees also include medical insurance covering fee-for-service medical care; and be it further

RESOLVED, That the Florida Medical Association, should such legislation be introduced, mount a statewide campaign to ensure passage of this legislation by educating the public and obtaining public support; and be it further

RESOLVED, That the American Medical Association seek the introduction of similar legislation in the U.S. Congress."

RESOLUTION 86A-34
Contingency Fees for Frivolous Lawsuits
Duval County Medical Society

The motion of the Reference Committee to amend Resolution 86A-34 by striking on line 10 "an equivalent percentage" and inserting "a portion" carried.

Resolution 86A-34 was adopted as amended.

RESOLUTION 86A-34

Contingency Fees for Frivolous Lawsuits

RESOLVED, That the Florida Medical Association seek the enactment of legislation requiring an attorney who files a liability suit on a contingency fee basis, to pay a portion of the defendent's court cost if the suit is lost.

RESOLUTION 86A-38
Expert Witness
Dade County Medical Association

The motin of the Reference Committee to amend Resolution 86A-38 by, on line 10 after the word ''licensed'' insert: ''and actively practicing;'' on line 10 after the word ''least'' insert: ''the past;'' on line 11 delete the word ''this'' and on line 11 after the word ''activity,'' insert: ''as an expert witness'' carried.

The amended resolve read as follows:

RESOLVED, that FMA promote legislation that an expert witness be licensed and actively practicing in the state and have practiced in his specialty for at least the past four years, with less than 10% of his income from medical practice in a given year being derived from activity as an expert witness, prior to his giving testimony in court or by deposition in said state in which an alleged incident had occurred.

Resolution 86A-38 was adopted as amended.

RESOLUTION 86A-38

Expert Witness

RESOLVED, That FMA promote legislation that an expert witness by licensed and actively practicing in the state and have practiced in his specialty for at least the past four years, with less than 10% of his income from medical practice in a given year being derived from activity as an expert witness, prior to his giving testimony in court or by deposition in said state in which an alleged incident had occurred.

RESOLUTION 86A-41
Vaccine Related Injury Legislation
Dade County Medical Association

The motion of the Reference Committee to amend Resolution 86A-41 by inserting after the word ''injuries'' ''which are due to vaccines required by state law or regulation'' carried.

Resolution 86A-41 was adopted as amended.

RESOLUTION 86A-41

Vaccine Related Injury Legislation

RESOLVED, That the Florida Medical Association actively seek the passage of state "no fault" legislation for vaccine related injuries which are due to vaccines required by state law or regulation.

RESOLUTION 86A-42
Personal Responsibility
Dade County Medical Association

Resolution 86A-42 was not adopted.

RESOLUTION 86A-44
Malpractice Coverage for Physicians Providing Indigent Care
Palm Beach County Medical Society

Resolution 86A-44 was adopted.

RESOLUTION 86A-44

Malpractice Coverage for Physicians Providing Indigent Care

RESOLVED, That the Florida Medical Association support extension of the State of Florida limited sovereign immunity to include physicians on contract with County Health Departments.

The Chairman expressed, on behalf of the Committee, its deep appreciation to FMA staff, Donald S. Fraser Jr., George S. Palmer Jr., Lucy Mohs and Helen Bradford for their assistance in the preparation of the report. The Committee also thanked all members of the Florida Medical Association who appeared before this Committee. The Chairman also thanked the members of his Committee, Paul T. Baroco, M.D.; James T. Cook III, M.D.; Wilbert L. Dawkins Sr., M.D.; Larry P. Garrett, M.D.; Charles A. Dunn, M.D.; Joseph C. Von Thron, M.D., AMA Delegate Advisor and Sanford A. Mullen, M.D., AMA Delegate Advisor.

The motion by the Reference Committee to adopt the report of Reference Committee IV, Legislation and Miscellaneous, as amended carried.

Report of Reference Committee No. V Medical Economics

Dr. Selander called the Chairman and members of Reference Committee No. V, Medical Economics, to present their report.

Dr. Peter A. Tomasello, Chairman, and his committee came forward to present the report of Reference Committee No. V, Medical Economics.

Report of the Council on Medical Economics

Supplemental Report Council on Medical Economics

The motion of the Reference Committee to adopt the Report of the Council on Medical Economics and the Supplemental Report of the Council on Medical Economics carried.

Council on Medical Economics
Charles P. Hayes Jr., M.D., Co-Chairman
Richard S. Hodes, M.D., Co-Chairman

The Council on Medical Economics held four meetings during the 1985-86 Association year: September 27, 1985; March 29, 1985; and conference calls on September 18, 1985, and May 16, 1986. During the Association year, the Council on Medical Economics addressed many important issues and completed several projects.

Resolution 85-2, entitled "Alternative Delivery Systems," was referred to the Board of Governors requesting the FMA to place more emphasis on providing information to its membership regarding alternative health delivery systems. This resolution further called for the development of a strategy and plan of action that could be used by physicians, individually and collectively, in competing with these systems and that appropriate funding and staffing be added to bring this program into fruition as soon as possible.

As a result of the resolution, the FMA Council on Medical Economics helped create the Contract Evaluation Section of the Medical Economics Department having the main purpose of reviewing provider contracts offered by the various prepaid plans. The Medical Economics Department has kept up-to-date files on the various prepaid plans operating in the state and this information has been made available to the membership upon request. The Department, in cooperation with the Florida Physicians Association, was successful in the completion of a physician contracting guide, a guide used to aid physicians in negotiating with prepaid plans.

The Council studied the various financial alternatives for indigent care in the state of Florida through the existing Medicaid program and through several other alternatives and was responsible for sponsoring several legislative bills addressing this issue. The Council was also intricately involved in the development of a feasibility study on prepaid plan activity which resulted in the Board of Governors establishing an Ad Hoc Committee to further study this issue.

The Council reviewed in detail proposed position papers on competition and the cost of health care prepared by FMA staff. The Council felt that these papers should be adopted as resource documents to be made available to the membership.

The Committee on Workers' Compensation spent a tremendous amount of time in developing testimony to be presented to the Three Member Panel in an effort to increase the reimbursement level of the fee schedule. The Committee on Health Care Delivery, the Subcommittee on Health Care Financing and Alternative Delivery Mechanisms, Subcommittee on Government Programs, and Subcommittee on Business Coalition studied issues pertaining to indigent care, health care financing, the reorganization of the Department of Health and Rehabilitative Services, HMO accreditation, and activities relating to the Office of Technical Assistance of the Hospital Cost Containment Board. Significant time was devoted to the development of proposed legislation that would provide health care to indigent patients and the method in which this health care would be given. All the committees under the Council on Medical Economics were very active during the Association year. A summary of these activities is reported below.

Committee on Workers' Compensation

The Committee on Workers' Compensation, chaired by Howard A. Kurzner, M.D., presented testimony before the Three Member Panel on February 6, 1986, in Tallahassee, supporting the establishment of an increase in the Workers' Compensation fee schedule. The FMA has experienced resistance from the Three Member Panel in the past in asking for increases in pay-out of the Workers' Compensation fee schedule. During the 1984-85 Association year, a 4.2% increase was granted in actual pay-out. During the 1985-86 Association year, the FMA was granted a 3.1 percent increase representing a 7.3 percent increase over a two-year period.

The Committee on Workers' Compensation met several times during the Association year and retained John Lewis, Esq., a consultant expert in the field of Workers' Compensation. The Committee hopes to utilize Mr. Lewis' background in the area of Workers' Compensation law in improving the mechanisms available to FMA in seeking higher reimbursement levels in the Workers' Compensation fee schedule.

At his presentation to the Three Member Panel on February 6, 1986, Dr. Kurzner stated that the panel has historically placed more weight upon the cost to employers than the cost to the health care system. On the other hand, physicians have been treating patients relatively at the same level of reimbursement for the past five years. From 1980-1985, the all-items category of the Consumer Price Index increased 26.3 percent while the medical component increased 46.4 percent. Dr. Kurzner pointed out that the impact upon the health care system, as a result of the recent increase in Workers' Compensation reimbursement, has had a very minimal impact on the Florida health care system. Dr. Kurzner concluded his presentation to the Three Member Panel by stating that "subsequent annual revisions will continue to improve the

necessary balance between the quality of medical care and affordable cost. The relationship between the quality of care and rapid recovery is the greatest incentive to improve the Workers' Compensation program. The more quickly we move a patient from medical to rehabilitation care and then back to work, the lower the cost will be to all Floridians." Other testimony presented by the FMA included a discussion of the current economic environment by Robert W. Seligson, FMA Director of Medical Economics and a legal analysis of the current Workers' Compensation law in relationship to the Three member Panel.

Committee on Peer Review Organizations

The Committee on Peer Review Organizations, chaired by Paul J. Popovich, M.D., is responsible for monitoring the activities of the Professional Foundation for Health Care, Inc. (the statewide PRO). The Committee solicited several responses from various members of the FMA who have encountered difficulties with the Professional Foundation for Health Care (PFHC). As a result of the Board endorsing the FMA's involvement in establishing liaison with the Professional Foundation for Health Care, the Committee began working with the President of the Foundation, Thomas E. McKell, M.D., in an effort to address the problems the members have encountered.

In addition Arthur E. Eberly, M.D., also a member of the committee, was appointed to the Professional Foundation for Health Care Board and currently serves as Vice President of this organization, acting officially as FMA liaison to the PFHC. During the Association year the committee encouraged county medical societies and recognized specialty societies to participate in the monitoring process of the Professional Foundation for Health Care and report any problems back to the FMA PRO Committee.

The committee developed an article for the *FMA Today* for the purpose of educating the membership on how the statewide PRO functions, including detailing the mechanisms of the review process and emphasizing the need to properly document medical records. Throughout the year the committee recognized that documentation was one of the key reasons why physicians have had retrospective denials of their Medicare cases. It was recommended to the membership that they continue to take the time to provide the appropriate documentation as required.

The committee has also made several recommendations with regard to current PRO statutes including requesting that the Health Care Financing Adminstration revise the current attestation statement requirements that all signatures must match the attestation statement. There have been several cases identified which were perfectly well documented but because of the technical aspect of the attestation signature not matching the medical records signature, payment was retrospectively denied by the PRO. The committee will continue to work towards eliminating this problem.

Committee on Relative Value Studies

The Committee on Relative Value Studies met three times during the Association year and held several telephone conference calls for the purpose of developing the 1986 Florida Relative Value Studies. The 1986 Florida Relative Value Studies is based in its entirety on the 1986 AMA CPT-4 Current Procedural Terminology. The committee has updated every single relative value code that is found in the 1986 Relative Value Studies. Below is a comparison of 1986 codes versus 1982 codes.

Section	1986 Codes	1982 Codes
Medicine	667	523
Surgical	4,367	4,130
Radiology	702	671
Pathology	1,113	1,045

There are many codes that were added and deleted based on the 1986 AMA CPT-4 Current Procedural Terminology Book. Many new codes were eliminated. The 1986 Relative Value Studies is based on 36,403,000 charges of both Medicare and private charge data supplied by Blue Cross and Blue Shield of Florida, Inc. Input was received from 21 percent of the county medical societies and 42 percent of the recognized specialty societies regarding the draft 1986 Florida Relative Value Studies. Listed below are the county medical societies and specialty societies that responded:

County Medical Societies
Dade County Medical Association
Duval County Medical Society
DeSoto-Hardee-Glades County Medical Society
Pasco County Medical Society
Lee County Medical Society
Escambia County Medical Society
Indian River County Medical Society
Brevard County Medical Society

Specialty Societies
Florida Gastroenterological Society
Florida Chapter, American College of Chest Physicians
Council of Florida District Branches, American Psychiatric Association
Florida Orthopedic Society
Florida Society of Anesthesiologists
Florida Thoracic Society
Florida Urological Society
Florida Society of Clinical Oncologists
Florida Association of General Surgeons
Florida Academy of Family Physicians
Florida Chapter, American College of Emergency Physicians
Florida Society of Pathologists
Florida Society of Plastic and Reconstructive Surgery
Florida Society of Ophthalmology
Florida Society of Thoracic and Cardiovascular Surgeons
Florida Society of Dermatology
Florida Chapter, American College of Surgeons

The 1986 Relative Value Studies will be published in July 1986, and will be disseminated to the membership upon their request. The FMA has received numerous inquiries about the 1986 Relative Values Studies from around the country and it is anticipated that the sales of the 1986 Relative Values Studies will increase once word has spread that it has been published.

Ad Hoc Committee on Prepaid Plans

During the September 1985 meeting, the Council on Medical Economics developed a feasibility study on prepaid plans. An analysis was prepared on the current development of alternative delivery systems, and a letter was sent to all existing operating HMOs and PPOs in the state requesting specific information about their operations. In addition, a letter was sent out to every county medical society from the FMA Secretary, Henry M. Yonge, M.D., asking for any comments or suggestions they had pertaining to the FMA conducting a feasibility study of establishing a statewide prepaid plan. Every state medical association was polled regarding their activities pertaining to prepaid health plans and whether they were considering developing a statewide IPA similar to the Medical Association of Georgia. A legal opinion was requested from consulting legal counsel, William H. Adams III, as to the legal implications of the FMA establishing a statewide prepaid health care plan and the structure of individual practice associations. Subsequently, responses to Dr. Yonge's letter were received from 23 component county medical societies, representing 12,055 members, or 81 percent of the membership. Several of the major county medical societies, who have either developed a county medical society sponsored IPA or are in the developmental stages of creating one, responded negatively to the FMA developing some type of statewide IPA prepaid plan. Over 70 percent of the respondents felt the FMA should not consider developing a statewide IPA. Several small counties did respond favorably to the FMA studying the feasibility of developing a statewide IPA plan but, at the same time, recognized



Reference Committee No. V (Medical Economics) was chaired by Peter A. Tomasello, M.D., Plantation. Left to right: J.S.A. Wester, M.D., Hollywood; Virgil A. Ponzoli, M.D., Naples; Dr. Tomasello, standing; Mrs. Donna Campbell, Recorder; Daniel Seckinger, M.D., Miami; Robert G. Isbell, M.D., Tampa.

the enormous amount of planning and work that would go into studying such a project on a statewide basis.

Several options were made available to the FMA Board of Governors as a result of this study. Subsequently at the October Board Meeting, the Board of Governors approved the development of an Ad Hoc Committee on Prepaid Plans. This committee chaired by Frank C. Coleman, M.D., was given the purpose of studying the current prepaid plan activity situation in Florida and developing recommendations to the Board on how the FMA can participate in this type of activity. The Ad Hoc Committee met several times during the Association year and four recommendations were approved by the Board as follows:

1. That at the current time the FMA not consider developing a statewide sponsored IPA program, given the current competitive atmosphere as well as the cost constraints in establishing a statewide program;
2. Consider developing a network of quality assurance and utilization review programs for county medical societies as well as studying the feasibility of developing a uniform marketing and advertising program for existing county medical society sponsored prepaid plans;
3. Explore the feasibility of assisting county medical society sponsored IPAs in their effort to obtain financing for their prepaid plans; and
4. Consider the feasibility of joint venture with one or more existing HMO/IPAs as part of an effort to develop a statewide county medical society sponsored network of prepaid plans in cooperation with existing county medical society sponsored prepaid plans.

As a result of these recommendations passed by the Board, the FMA Ad Hoc Committee on Prepaid Plans as well as the Council on Medical Economics, began to study these recommendations and to come up with a plan of action. The FMA also retained Judith Mattison of Judith Mattison Incorporated, a consulting firm located in Bethesda, Maryland, who was responsible for helping the Medical Association of Georgia initiate their statewide IPA plan. Since that time, a study has been developed on all these recommendations and, at the time of this writing the recommendations are currently being studied by the Board of Governors for further action. It is anticipated that the Ad Hoc Committee will continue to be active in developing recommendations and in formulating policy with regard to the FMA involvement in prepaid plan activity.

Committee on Health Care Delivery

The Committee on Health Care Delivery, chaired by William J. Garoni Jr., M.D., was quite active having approved eight major recommendations, six of which emanated from its three subcommittees. On March 22, 1986, the Committee held a joint meeting with the chairman and members of the three subcommittees. This meeting was devoted entirely to indigent health care issues. Officials of the Department of Health and Rehabilitative Services discussed primary care and the role of county public health units as providers and brokers of indigent health care in concert with the private sectors of medicine. Representatives of the Center for Health Policy Reseach, University of Florida, presented a proposed study of uncompensated outpatient services provided by physicians to be undertaken in cooperation with the FMA. The meeting further enabled Charles P. Hayes Jr., M.D., Co-Chairman of the Council on Medical Economics, to review proposed legislation on indigent health care under consideration by the Florida Legislature. During the Interim and General Sessions of the Legislature, Dr. Hayes represcnted the FMA's position that indigent health care should be financed through a broad-based funding mechanism and be provided through county public health units to allow for greater flexibility by counties and greater involvement by the private sector. The Committee endorsed this approach to indigent health care.

The committee further served as the Technical Assistance Panel of the FMA. Dr. Garoni chaired the Technical Assistance Panel whose membership was composed of the three subcommittee chairmen and the two co-chairmen of the Council on Medical Economics. The Technical Assistance Panel achieved its major objective, as approved by the House of Delegates during the 1985 Annual Meeting, of interfacing on a continuing basis with the Office of Technical Assistance of the Hospital Cost Containment Board. This led to direct FMA involvement in publications of the Hospital Cost Containment Board dealing with average physician charges and outpatient surgeries. Objectives of the Technical Assistance Panel will continue to be that of improving future editions of government publications on medical care services and to be appropriately involved in the broad responsibilities of the Hospital Cost Containment Board and the Office of Technical Assistance as they relate to the health care delivery system.

Subcommittee on Business Coalition

The Subcommittee on Business Coalition, chaired by Thomas

E. McKell, M.D., held a joint meeting with the FMA Technical Assistance Panel on September 6, 1985. The purpose of this meeting was to receive information from the Office of Technical Assistance of the Hospital Cost Containment Board regarding its activities with business coalitions throughout the state and the status of health care/business coalition development in Florida. The second purpose was to afford the Technical Assistance Panel with the opportunity of reviewing the detailed brochure on outpatient surgery being developed by the Office of Technical Assistance. The subcommittee recommended that the Technical Assistance Panel interface with the Council on Specialty Medicine in order to meet the objectives for which the Technical Assistance Panel was established, including the development of cost effective information on the practice of medicine. This recommendation also included provisions to enable the FMA to exchange information based upon the expertise of the various specialties with such governmental entities as the Office of Technical Assistance and agents of private businesses such as health care coalitions.

Subcommittee on Government Programs

The Subcommittee on Government Programs, chaired by James K. Conn, M.D., held an important meeting on July 19, 1985, that was devoted to issues pertaining to elderly and long-term care. Recommendations were approved by the subcommittee relating to the district offices of HRS and county medical societies and the establishment of liaison committees to assist HRS at the Community level in meeting the long-term health care needs of the elderly. Other recommendations approved related to establishing liaison at the state level with various HRS offices involved with regulating medical care provided in long-term care facilities, and further, to provide input to HRS on viable alternatives to nursing home care. The subcommittee also recommended that the FMA participate with the state of Florida in actuarial studies to determine the feasibility of long-term care being developed in Florida by private insurers.

On September 20, 1985, the Subcommittee on Government Programs met to discuss House Bill 1427 which passed the 1985 session of the Florida Legislature. House Bill 1427 called for the reorganization of the Department of Health and Rehabilitative Services (HRS). This recommendation, as approved by the Subcommittee on Government Programs, called for the reintroduction of the term "State Health Officer" within Florida statutory law along with appropriate responsibilities and authorities. The 1986 Session of the Florida Legislature enacted a law which creates a Deputy Assistant Secretary for Health within HRS who, by law, shall be an M.D. or a D.O. and serve as Florida's State Health Officer. The subcommittee further endorsed the FMA's response to the Florida House of Representatives Committee on Health Care and Insurance's "Summary of Laws Impacting Health," which was an in-depth analysis by the FMA of the Florida Statutes relating to public health and private health care and the appropriate role of government.

Subcommittee on Health Care Financing and Alternative Delivery Mechanisms

The Subcommittee on Health Care Financing and Alternative Delivery Mechanisms, chaired by Jack W. MacDonald, M.D., held a conference call meeting on September 17, 1985. This meeting resulted in the development of the FMA's position on indigent health care. This recommendation called for the FMA to seek adequate funding of indigent and medically indigent health care through broad-based revenue funding and that services provided to the indigent and medically indigent be delivered through a private-sector provider system that includes independent practitioners with emphasis on primary care and preventive medicine. On the basis of this recommended position, the FMA developed a concept paper on indigent health care that ultimately was embraced by legislative sponsors in the Florida House of Representatives and the Florida Senate which put the FMA in a very favorable light on this issue which, again will be a major legislative issue in 1987.

The Subcommittee Chairman and related FMA Staff were appointed to the Health Maintenance Organization (HMO) Advisory Council of the Department of Insurance and its Subcommittee on Quality Health Care, which began meeting in May of 1986. The purpose of the Advisory Council is to implement rules resulting from the 1985 HMO law.

Supplemental Report
Council on Medical Economics

Ad Hoc Committee on Prepaid Plans. The Committee met on June 23, 1986 and discussed in detail several of the options for the FMA to consider in regard to alternative delivery systems. They included the study of the development of a network of existing and developing CMS-sponsored HMO/IPA plans, the feasibility of joint ventures with insurance companies, statewide and national HMO/IPA plans or with other related entities and the feasibility and alternatives of providing financial assistance to the development of physician-sponsored prepaid plans in Florida.

The Committee felt that the creation of a management services company would provide a combination of all three of the options previously discussed as well as allowing physician leadership at both the management company and local HMO/IPA levels. The Board approved in principle a recommendation for the establishment of a mechanism such as a management services company to support the present and future development and operations of physician-sponsored HMO/IPA and other managed care programs to include support services, marketing and the coordinating of potential statewide CMS-sponsored plans. As a result of this recommendation, the Committee is in the process of reviewing the detailed proposal submitted by Judith Mattson, Inc., to implement the development of the management services company. It is anticipated that a plan of action will be developed and completed to be submitted to the FMA Board of Governors for approval at its fall meeting in October.

Report of the
Council on Hospital Medical Staffs

The motion of the Reference Committee to adopt the Report of the Council on Hospital Medical Staffs carried.

Council on Hospital Medical Staffs
Thomas M. Daniel, M.D., Chairman

The Council on Hospital Medical Staffs met three times during the Association year: on September 14, 1985, a statewide meeting was held in conjunction with the FMA Leadership Conference; on January 24, 1986; and on May 10, 1986. During the Association year the Council on Hospital Medical Staffs was very active in addressing many key issues including joint ventures, risk management, hospital medical staffs relationship to the hospital administration and governing boards, and allied health professionals seeking hospital privileges.

The Council took the position, with regards to allied health professionals, that if there was consideration within the Florida Legislature expanding the particular privileges of certain allied health professionals, the Council would work with the Council on Legislation in educating legislators about the health care industry and arrange for site visits to individual hospitals. Both the Council on Hospital Medical Staffs and the Council on Medical Economics studied the Certificate of Need issue intently. The Council recommended that the FMA propose a three to four year phase out program of the Certificate of Need Program to include:

1. No expansion of the current CON program;
2. Streamline the current CON process to eliminate delays in unnecessary litigation;

3. To oppose the financing of local health councils through the funding of Certificate of Need application fees. The financing of local health councils should be the responsibility of all citizens of Florida; and
4. That the threshold level for equipment be increased to 1,500,000.

The Council is pleased to report that during the Association year, John M. McBryde, President of the Florida Hospital Association, attended all meetings of the Council on Hospital Medical Staffs. The Council feels that it is imperative to have a strong working relationship exist between the FMA and FHA. Throughout the year the Council emphasized the importance of maintaining this relationship and felt that it would allow issues to be addressed in a very diplomatic and straightforward manner and hoped that the Florida Hospital Association would continue working with the FMA's Council on Hospital Medical Staffs in addressing issues of common concern.

The Council also studied the issue of joint ventures. The Council felt that at the current time no policy should be developed to address the issue of joint ventures. However, the Council did recommend that the physician/hospital joint ventures must meet the test in promoting the interest of patients by providing quality care in a cost effective manner at all times.

The Council on Hospital Medical Staffs also publishes a quarterly newspaper to report on activities of the Council and on the AMA Hospital Medical Staffs Section. The Council hopes to continue to publish this quarterly newsletter that is disseminated to Chiefs of Hospital Medical Staffs throughout the state.

The Council has encouraged county medical societies to develop their own local hospital medical staffs committees composed of representatives from hospital medical staffs in their county. It was felt that by developing local hospital medical staffs committees, a good network of communication from the local grass roots physician to the statewide council would be created. The chairman made several visits to county medical societies to report on the activities of the Council and to encourage county medical societies to establish their own local hospital medical staff committees.

During the January 24 Council on Hospital Medical Staffs meeting which representatives from over 35 percent of the Florida hospitals attended, several guest speakers were invited to give presentations. They included Lester Abberger, from the Florida Hospital Cost Containment Board; Mr. John McBryde, President of the Florida Hospital Association; Thomas C. Peebles, M.D., Chairman of the AMA Hospital Medical Staffs Governing Council; and Thomas R. Reardon, M.D., Delegate to the AMA Hospital Medical Staffs Section.

Mr. Abberger spoke about competition in health care and stated the role of consumers is to make the right choices in the various alternatives that are available to them. He also discussed in great detail the role of government in the financing of health care including health care cost containment. He concluded his presentation by saying the Office of Technical Assistance's role is to help promote competitive health care activity in the marketplace.

Mr. McBryde spoke on four main issues, that included:

1. Tax exempt financing undergoing scrutiny by the government;
2. The Medicare rate of payment which is a growing concern of The Florida Hospital Association, physicians and the elderly population;
3. The great concern with regard to anticipated Medicare cuts and the effect this will have on the delivery of health care for the elderly; and
4. The financing of indigent care which will probably be one of the major legislative issues in the upcoming session.

Thomas C. Peebles, M.D., and Thomas R. Reardon, M.D., spoke on current hospital medical staff activities on a national level. Dr. Peebles encouraged the development of local hospital medical staffs committees as well as the participation in the newly developed FMA Council on Hospital Medical Staffs. He stressed the fact that the development of the AMA HMSS and the Council on Hospital Medical Staffs is an excellent forum to address issues pertaining to hospital medical staffs. Dr. Peebles elaborated on the growth of the AMA Hospital Medical Staffs Section and how he envisions this section growing based on the participation in the last three Hospital Medical Staffs Annual Meetings.

Dr. Reardon gave the Council a report on the activities of the AMA Hospital Medical Staffs Section placing emphasis on the legal status and self-governing of the Hospital Medical Staffs and how these issues will continue to be heavily debated and studied by the AMA Hospital Medical Staffs Section.

The issue of Medicare denials was discussed by the Council. The Council detailed several instances in which Medicare has not allowed for reimbursement for procedures that are normally performed under routine physicals and pre-surgical procedures. As a result of the problems encountered and identified with the HCFA regulations, a resolution was developed by the Florida State Delegation to the AMA Hospital Medical Staffs Section. The resolution asked the AMA to communicate these inefficiencies in the Medicare program to the Health Care Finance Administration to establish a mechanism to provide medical input into the development of future regulations, and the revision of existing statutes to ensure that the patient receives the best medical care available.

Committee on Risk Management

The Committee on Risk Management was very active during the 1985-86 Association year and met several times in an effort to develop an educational program on risk management. The purpose of the Committee on Risk Management is to develop educational programs to help reduce medical malpractice. The Risk Management Committee recommended that a risk management program be developed to educate the physicians on ways to reduce medical malpractice as well as ways to develop procedures for the individual physician to follow when a suit has been filed. In addition, the Committee also recommended that the FMA encourage specialty societies to develop malpractice preventive standards for their members and information pertaining to individual lawsuits should be made available to these specialty societies upon request through the medical association sponsored insurance company. It is also recommended by the Council that articles be published frequently in the *FMA Today* highlighting changes in the malpractice law and centering on areas which need to be addressed by physicians pertaining to frequency of malpractice claims. The Committee on Risk Management also reviewed the issues including confidentiality of patient records, identifying major loss leaders, expert witnesses, incident reporting, contractual obligations, and in-office monitoring. One of the major accomplishments of the Committee on Risk Management was the development of a risk management educational program to satisfy the five hour state requirement. On May 31, 1986, the Committee, in concert with the Florida Physicians Insurance Company, conducted their first seminar on risk management before 65 doctors from the Dade and Broward County Medical Associations. Since that time, the Committee has received numerous requests from specialty societies, county medical societies, and hospitals from around the state who are interested in the FMA conducting this program. The Committee will sponsor a risk management program at the Florida Academy of Family Physicians Annual Meeting in June, and it is anticipated that several more seminars will be conducted over the summer prior to the Annual Meeting. The Committee hopes to finalize their risk management program to include developing individual risk management programs for some of the high risk specialties such as OB-GYN, anesthesiology and surgery. It is anticipated that by gearing risk management programs to the individual high risk specialty, physicians will be better able to relate to the different problems pertaining to their practice that cause malpractice to occur.

Report E of the Board of Governors

The motion of the Reference Committee to adopt Report E of the Board of Governors carried.

Report E of the Board of Governors

FMA Councils and Committees

COUNCIL ON MEDICAL ECONOMICS

The Annual Report of the major activities of the Council on Medical Economics is included in this section of the Delegates' Handbook. The Board of Governors has carefully reviewed the activities of the Council during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Professional Foundation for Health Care: The Board approved the recommendation that the FMA establish liaison with appropriate physician representatives of the Professional Foundation for Health Care (PFHC) in order to develop a mechanism to effectively address problems which have been created by the present statewide PRO.

Council on Hospital Medical Staffs: The Board approved the recommendation that the Council on Hospital Medical Staffs be encouraged to invite representatives from each hospital in the state to notify the Council on Medical Economics of any problems they have encountered with the PRO for their review and study. This information will be forwarded to the Committee on PRO for their review and action as appropriate.

Certificate of Need: The Board of Governors approved the recommendation that the FMA require the Statewide Health Council to include physician representation from nominees recommended by the FMA to participate in the Certificate of Need Task Force proposed by the Statewide Health Council.

Prioritization of Projects to be Completed by the Council: The Board approved the establishment of priorities of projects to be completed by the Council on Medical Economics. These priorities include:

1. Resolution 85-2, Alternative Delivery Systems and Physicians Contracting Guide. This resolution is in concert with the Medical Economics priority approved by the Board of Governors asking that priority be given to the establishment of a section within the Medical Economics Department to monitor the rapid escalation of alternative health care delivery systems and the impact on the traditional fee-for-service system of health care delivery, and that this be carried out in the most expedient manner possible within the current staff structure of the FMA.
2. Development of the 1986 Relative Value Studies Book.
3. Resolution 85-4, Workers' Compensation. This resolution calls for the FMA to retain expert legal counsel knowledgeable of workers' compensation law for the purpose of legal and/or other actions against the appropriate party or parties to accomplish the goals of Resolution 83-7.
4. Peer Review Organizations. The Board directed the FMA to continue to monitor this priority which requests the FMA to continue to monitor the activities of the Professional Foundation for Health Care in Tampa, and to continue to collect and evaluate any problems FMA members encounter through the PRO.
5. Medicaid Funding, Primary Care, and Indigent Care.
 Medicaid Funding — The Board directed that the FMA examine all alternative prepaid Medicaid plans and determine the extent of funding needed to establish such programs for implementation through county medical societies.
 Primary Care — The Board requested the Department of Health and Rehabilitative Services to provide an ongoing report of the development of the DHRS Primary Care Program, and that the FMA and several specialty societies provide input to this program on an ongoing basis.
 Indigent Care — The Board approved the development of a recommendation to submit to the proper governmental authorities to address the issue of adequate health care for the indigent, and requested the Council to proceed with the recommendation in concert with the Council on Legislation.

Professional Foundation for Health Care: The Board approved the recommendation that the FMA inform the membership that the FMA is working closely with the Professional Foundation for Health in order to address problems the membership has encountered with the PRO.

Feasibility of Establishing a Statewide IPA Plan: The Board tabled a recommendation from the Council on Medical Economics that the FMA not establish a statewide HMO/IPA at the present time, and authorized the President to appoint an Ad Hoc Committee to further study the issue of a statewide IPA and report to the Board at its next meeting.

Information on Prepaid Plans: The Board approved a recommendation that the FMA continue to develop information on prepaid plans, through the Department of Medical Economics as a clearinghouse, in order to provide the membership with up-to-date information on prepaid health plan activities.

Quality Assurance Review Programs: The Board approved the recommendation that the FMA develop a quality assurance review program to be used by various prepaid plans in Florida.

Workers' Compensation: The Board retained legal counsel with expertise in workers' compensation law to develop a plan of action to address the problems with reimbursement, as well as to develop a proposal that outlines a mechanism for the FMA to negotiate future workers' compensation fee schedules.

Medical Societies Competing with Alternative Delivery Systems: The Board approved the recommendation that the FMA support county medical societies in their efforts to compete with other alternative delivery systems.

Medical Societies Liaison Committees: The Board recommended to the Secretary of the Department of Health and Rehabilitative Services (HRS), that the district offices request each county medical society in its district to either appoint a liaison committee or representative to a district-wide liaison to assist HRS at the community level in meeting the long-term health care needs of the elderly; and furthermore, that the FMA encourage the county medical societies to cooperate with this effort.

Liaison to HRS: The Board approved the recommendation that the FMA offer to the Secretary of the Department of Health and Rehabilitative Services (HRS) the appointment of a physician liaison to each of the following HRS programs: Aging and Adult Services Program; Office of Licensure and Certification; and Medicaid Program Development, for the purpose of providing input on improving current state regulations pertaining to the provision of medical services in long-term care facilities for the elderly and related matters such as alternatives to nursing home care.

Health Care Insurance: The Board approved the recommendation that the FMA participate with the state of Florida in an actuarial study to determine the feasibility of long-term care insurance plans being developed in Florida by private insurers for the provision of medical and health related services in nursing homes and similar long-term care facilities.

Technical Assistance Panel: The Board approved the recommendation that the Technical Assistance Panel of the Council on Medical Economics interface with the Council on Specialty Medicine in order to meet the objective for which the Technical Assistance Panel was established, including the development of cost effective information on the practice of medicine; and, further, to

enable the FMA to exchange information based upon the knowledge of various specialties with such governmental entities as the Office of Technical Assistance and agents of private businesses such as health care coalitions.

Committee on Relative Value Studies: The Board received a report regarding the current status of the 1986 Florida Relative Value Studies scheduled to be published in August 1986. The Committee on Relative Value Studies has received and approved the data to be used in preparation of this revised edition which has been previously disseminated to county medical societies and specialty societies for their review and comment.

Peer Medical Utilization Review: The Board authorized the Florida Medical Foundation's Committee on Peer Medical Utilization Review to perform Medicare peer review for Blue Cross and Blue Shield of Florida, Inc., at a flat fee of $1,225 per case. In addition, the Board approved the recommendation that the FMA offer a limit on county medical society Medicare peer review administrative and professional expenses to $500 per case, and that the FMA revise the Florida Medical Foundation's operating procedures by eliminating the clause that provides reimbursement of one member of the local Peer Review Committee and the county executive to attend and participate in the state PMUR Committee Meetings.

Statewide IPA Program: The Board approved the recommendation that the FMA not consider developing a statewide-sponsored IPA program at the present time. It was felt with the current competitive atmosphere, as well as the cost constraints involved in establishing a statewide program it would not be feasible to enter into such an undertaking.

Coordination of County Medical Society Sponsored Plan: The Board approved the recommendation that the FMA consider developing a network of quality assurance and utilization review programs for the county medical societies, as well as study the feasibility of developing a uniform marketing and advertising program for existing county medical society sponsored prepaid plans.

Financial Assistance for Developing Alternative Delivery Systems: The Board approved a recommendation that the FMA explore the feasibility of assisting county medical society sponsored IPAs in their efforts to obtain financing for their prepaid plans.

Joint Ventures: The Board approved the recommendation that the FMA consider the feasibility of a joint venture with one or more existing HMO/IPAs as part of an effort to develop a statewide county medical society sponsored network of prepaid plans in cooperation with existing county medical society prepaid plans.

Management Services Company: The Board approved in principle that the FMA study the feasibility of establishing a mechanism, such as a management services company, to support the present and future development of operations of physician sponsored HMO/IPAs and other managed care programs to include support services, marketing, and the coordinating of a potential statewide network of county medical society sponsored plans.

Attestation Statements: The Board approved the recommendation that the FMA request that the AMA work with the Health Care Finance Administration in revising the rule involving signature requirements on the medical attestation statement.

Workers' Compensation: The Board approved the recommendation that the FMA begin conducting a feasibility study on developing improved mechanisms of adequate reimbursement under the current workers' compensation program.

COUNCIL ON HOSPITAL MEDICAL STAFFS

AMA/HMSS Breakfast Caucus: The Board approved the recommendation that the FMA sponsor the Florida state breakfast caucuses at the AMA Annual and Interim Meetings of the Hospital Medical Staffs Section on an ongoing basis.

Hospital Insurance Requirements: The Board asked the FMA legal counsel for a legal opinion on the mandatory insurance requirement that is being mandated by some of the malpractice insurers in the state. Some hospitals are requiring physicians with hospital privileges to maintain $1,000,000/$1,000,000 coverage, in which insurance companies are requiring hospitals to enforce as a condition for their hospital insurance coverage.

Risk Management: The Board approved the recommendation that the FMA Committee on Risk Management be allowed to establish a statewide working relationship with hospital risk managers in order to be able to identify key problem areas when the physician is at risk, as well as assisting the hospital in loss prevention. In addition, the Board approved the recommendation that the FMA, through the Committee on Risk Management, develop an organized network for the individual physician to contact when he is being notified of cancellation by his insurance carrier.

Joint Ventures: The Board approved the recommendation that the FMA adopt a policy pertaining to joint ventures between physicians and hospitals that the ultimate primary role of the physician is to provide the best quality care possible to the patient at the most economic cost at all times.

FMA Bylaws: The Board approved the recommendation that the FMA Bylaws be amended to provide that the Council on Hospital Medical Staffs be the designee to appoint the individual council member who will be the voting delegate in the House of Delegates.

Risk Management Committee: The Board approved the recommendation that the FMA revise the major goal of the Committee on Risk Management from "developing educational programs to prevent medical malpractice" to "developing a program in an effort to prevent and reduce medical malpractice."

Florida Hospital Association: The Board reviewed the informational item pertaining to the Council establishing a better communication with the Florida Hospital Association and recognize the importance of this effort.

Development of Risk Management Program: The Board of Governors approved the recommendation that the FMA, through the Council on Hospital Medical Staffs Committee on Risk Management, develop a risk management program to educate physicians on ways to reduce medical malpractice as well as ways to develop procedures for the individual physician to follow when a suit has been filed; and further, that this program be developed to satisfy the state five-hour CME requirement in risk management for physicians.

Malpractice Prevention Standards: The Board approved the recommendation that the FMA Committee on Risk Management act as a catalyst to encourage specialty societies to develop malpractice prevention standards for their specialties and that this information be disseminated to their membership; and further, that the FMA provide the specialty societies with statistical information as needed.

Update on Medical Malpractice Laws: The Board approved the recommendation that the FMA publish on a timely basis in *FMA Today* updates on the changes in malpractice laws for the purpose of educating the membership on the specific changes that are taking place.

Risk Management Seminar: The Board approved the recommendation that the FMA Committee on Risk Management conduct a risk management seminar in conjunction with the FMA 1986 Annual Meeting in Hollywood, Florida. It was also recommended that a nominal fee be charged for participation in this program and it be directed at all specialties. This program will be developed to satisfy the state five-hour CME requirement for risk management.

Report F
of the
Board of Governors
House of Delegates Referrals

The motion of the Reference Committee to adopt Resolution 85-4, Workers' Compensation Medical Fee Schedule, carried.

RESOLUTION 86A-5
Capitation as a Payment Mechanism for Medicare
Palm Beach County Medical Society

Resolution 86A-5 was adopted.

RESOLUTION 86A-5

Capitation as a Payment Mechanism for Medicare

RESOLVED, That the Florida Medical Association urge the United States Congress, the Health Care Financing Administration, and the President to immediately halt the expansion of federal capitation programs for Medicare, Medicaid, and Champus until the problems that have surfaced in Florida and elsewhere around the country can be thoroughly evaluated; and be it further

RESOLVED, That the Florida delegation to the American Medical Association submit this resolution to the 1986 AMA Interim session in December.

RESOLUTION 86A-27
Blue Cross/Blue Shield Payments
Dade County Medical Association

Resolution 86A-27 was not adopted.

RESOLUTION 86A-28
Insurance Claim Payments
Dade County Medical Association

The motion of the Reference Committee to refer Resolution 86A-28 to the Board of Governors with the suggestion that the Florida Medical Association obtain the appropriate background data to resolve this issue carried.

RESOLUTION 86A-28

Insurance Claim Payments

(Referred to Board of Governors)

Whereas, insurance companies allowed to operate in Florida have frequently failed to make payments in a timely manner; therefore be it

RESOLVED, That the Florida Medical Association request that the Insurance Commissioner institute and enforce a reasonable reimbursement period for payment of claims to the physician (30 days from date of receipt of insurance claim to date of payment to the physician by Florida registered insurance carriers). Prevailing interest rates shall be added to the base charge for failure to comply.

RESOLUTION 86A-29
Medicare PRO Advisory
Polk County Medical Association

Resolution 86A-29 was adopted.

RESOLUTION 86A-29

Medicare PRO Advisory

RESOLVED, That Florida Medical Association urge all physicians in the state of Florida warn their Medicare patients that due to PRO policy the cost of their hospitalization may not be paid, either in part or in whole, by Medicare, if a retrospective denial is issued by the PRO, but that this possibility has no relationship to their physician's opinion, experience or judgment.

RESOLUTION 86A-31
Medicare Claims Rejection
Pinellas County Medical Society

The motion to amend Resolution 86A-31 by adding the following resolveds carried:

RESOLVED, That the Florida Medical Association contact Blue Cross/Blue Shield of Florida, Inc., and inform them as to the current standards of medical care and request that they seek the modification of the policy of denial of payment for concurrent care by more than one physician by whatever means are feasible, and be it further

RESOLVED, That the Florida Medical Association use its public relations facilities to educate the senior citizens as to the causes of Medicare payment delays or refusals.

The motion from the floor for the following additional resolved carried:

RESOLVED, That the Florida Medical Association educate physicians on the proper preparation of claim forms in the cases where concurrent care has been provided.

Resolution 86A-31 was adopted as amended.

RESOLUTION 86A-31

Medicare Claims Rejection

RESOLVED, That the Florida Medical Association, the American Medical Association and the Florida Congressional Delegation enter into serious negotiations with Health and Human Services, Health Finance Administration and Blue Cross/Blue Shield of Florida to eliminate Medicare claims rejection for unsound medical reasons, and be it further

RESOLVED, That the Florida Medical Association contact Blue Cross/Blue Shield of Florida, Inc. and inform them as to the current standards of medical care and request that they seek the modification of the policy of denial of payment for concurrent care by more than one physician by whatever means are feasible, and be it further

RESOLVED, That the Florida Medical Association use its public relations facilities to educate the senior citizens as to the causes of Medicare payment delays or refusals, and be it further

RESOLVED, That the Florida Medical Association educate physicians on the proper preparation of claim forms in the cases where concurrent care has been provided.

RESOLUTION 86A-35
PRO Programs
Capital Medical Society

The motion of the Reference Committee to amend Resolution 86A-35 by deleting "make arrangements for" on line 43 and the word "continue" be inserted at the beginning of line 43 and an additional resolve to read as follows:

RESOLVED, That the Florida Medical Association strongly recommends that a physician of the Professional Foundation for Health Care, Inc., the statewide PRO, review all denials carried.

The motion from the floor for the following additional resolved carried:

"RESOLVED, that reconsideration of denials be done by subspecialty peers at the reconsideration level."

Resolution 86A-35 was adopted as amended.

RESOLUTION 86A-35

PRO Programs

RESOLVED, The Board of Governors of the Florida Medical Association continue monitoring of the Florida PRO and resolution of problems related to the operation of that organization, and that the House of Delegates instruct its AMA Delegates to request the American Medical Association, in conjunction with the American Hospital Association, to work with appropriate federal officials in an attempt to resolve problems with PROs, and be it further

RESOLVED, That the Florida Medical Association strongly recommends that a physician of the Professional Foundation for Health Care, Inc., the statewide PRO, review all denials; and be it further

RESOLVED, That reconsideration of denials be done by subspecialty peers at the reconsideration level.

RESOLUTION 86A-39
Medicare Toll-Free Access
Dade County Medical Association

Resolution 86A-39 was adopted.

RESOLUTION 86A-39

Medicare Toll-Free Access

RESOLVED, That the Florida Medical Association urge Blue Cross/Blue Shield of Florida to make available a 24-hour toll free phone line for use by physicians and hospitals to determine if a patient's Medicare benefits have been transferred to a HMO or CMP.

RESOLUTION 86A-43
Alternative Delivery Systems
Hernando County Medical Society

Considerable testimony was heard by the Reference Committee that this resolution not be adopted in accordance with the Supplemental Report of the Council on Medical Economics, Ad Hoc Committee on Prepaid Plans.

Resolution 86A-43 was not adopted.

The Reference Committee expressed its gratitude to all FMA members and staff who appeared before the Committee.

The Reference Committee Chairman said that he was fortunate to work with a most efficient and informed Committee: Robert G. Isbell, M.D.; Virgil A. Ponzoli, M.D.; J. S. A. Wester, M.D.; Daniel L. Seckinger, M.D.; T. Byron Thames, M.D., AMA Delegate and Lee A. Fischer, M.D., AMA Delegate. He expressed appreciation to Charles P. Hayes Jr., M.D., and Richard S. Hodes, M.D., Co-Chairmen of the Council on Medical Economics, and T. M. "Dan" Daniel, M.D., Chairman of the Council on Hospital Medical Staffs, for their outstanding effort on behalf of FMA members this past year.

The Reference Committee also thanked Mrs. Donna Campbell, Mrs. Betty Daly, Mr. E. Russell Jackson Jr., and Mr. Robert W. Seligson for their able assistance in the preparation of this report.

The motion of the Reference Committee to adopt the report of Reference Committee No. V as amended carried.

EMERGENCY RESOLUTION
Workers' Compensation Reimbursement Schedule

A motion from the floor carried to adopt the Emergency Resolution as presented by Dr. Darrel W. Wyatt, Clay County.

EMERGENCY RESOLUTION

Workers' Compensation Reimbursement Schedule

RESOLVED, That the Florida Medical Association immediately investigate the circumstances concerning the delay in publication of the 1986 Florida Workers' Compensation Reimbursement Schedule and report its findings to the constituent county medical societies.



Dr. James G. White addresses the House with his acceptance speech as President-Elect.

Election Results

At this time the Speaker, Dr. Selander, advised the members of the House of Delegates of the results of elections held for the office of President-Elect.

President-Elect

The Speaker announced that Dr. James G. White had been elected President-Elect. Dr. White was escorted to the podium by the entire Volusia County Delegation.

Acceptance Speech of President-Elect

Mr. Speaker, Officers of this Association, fellow members and guests. For twenty years I have been a member of the Florida Medical Association. In those years I have watched and served with a long line of able and outstanding presidents, who have lead the FMA through times of both turmoil and triumph. I have enjoyed working with the very capable staff of the FMA, many of whom I consider personal friends. I also have had the pleasure of getting to know many outstanding physicians and spouses statewide and you have become friends instead of just acquaintances. I fully realize your organized efforts and commitments throughout the entire state. Most especially I have seen first hand the efforts of the Volusia County Medical Society, its Auxiliary and the Gator Group without whose support, assistance and encouragement I would not be standing before you today.

I believe in the FMA; it is not just an organization existing solely for its own self interest. It is an organized group of individuals all concerned about the quality of care your patient receives, the directions your communities take and yes, the perception of the public. To paraphrase a quote "If you want a quiet life, you picked the wrong century in which to be born and practice medicine." Today we are looking at many new directions for medicine. Indeed, the health care delivery system is in a state of revolution. We must remain unified, not divisive, especially in the legislative and political arenas. Luis Perez has seved above and beyond the call of duty and Jim Perry has his work cut out for him. He will of course be assisted by a very capable Board of Governors. It is indeed an honor and a privilege to serve with such an outstanding and august body, to assist my friend Jim Perry and to accept the responsibilities of President-Elect. I want to thank each of you for your support and encouragement and most especially my patients, my office staff, my friends and my family. Thank you for this privilege.

Vice President
Secretary
Treasurer
Speaker of the House
Vice Speaker
District A — Board of Governors
Resident Physician — Board of Governors
AMA Delegate Seat #2
AMA Alternate Seat #2
AMA Delegate Seat #3
AMA Alternate Seat #3
AMA Delegate Seat #5
AMA Alternate Seat #5
AMA Delegate Seat #9
AMA Alternate Seat #9
AMA Delegate Seat #10
AMA Alternate Seat #10
AMA Delegate Seat #11
AMA Alternate Seat #11

Vice President — Kay K. Hanley, M.D.
Secretary — Henry M. Yonge, M.D.
Treasurer — Yank D. Coble Jr., M.D.
Speaker of the House — Guy T. Selander, M.D.
Vice Speaker — Arthur L. Eberly, MD..
District A — Gerold L. Schiebler, M.D.
Resident Physician — Keith E. McManus, M.D.

AMA Delegate Seat #2 — Joseph T. Ostroski, M.D.
AMA Alternate Seat #2 — James B. Perry, M.D.
AMA Delegate Seat #3 — Charles K. Donegan, M.D.
AMA Alternate Seat #3 — Lee A. Fischer, M.D.
AMA Delegate Seat #5 — Richard G. Connar, M.D.
AMA Alternate Seat #5 — Harold G. Norman, M.D.



Dr. Kay K. Hanley addresses the House with her acceptance speech as Vice President.

AMA Delegate Seat #9 — Kay K. Hanley, M.D.
AMA Alternate Seat #9 — T. Wallace Hahn, M.D.
AMA Delegate Seat #10 — Luis M. Perez, M.D.
AMA Alternate Seat #10 — Arthur L. Eberly, M.D.
AMA Delegate Seat #11 — Sanford A. Mullen, M.D.
AMA Alternate Seat #11 — Dick L. Van Eldik, M.D.

The new terms for Delegate Seats 2, 3, 5, 9, 10 and 11 are for two year terms beginning January 1, 1987 to December 31, 1988. Alternate Seats 2, 3, 5, 9, 10, and 11 will complete the term expiring December 31, 1988.

Committee on Membership and Discipline

The Vice Speaker then announced the results of District 9.

District 1: Lealis L. Hale Jr., M.D. (90)
District 2: James K. Conn, M.D. (90)
District 3: Samuel J. Alford Jr., M.D. (90)
District 4: H. Frank Farmer, M.D. (90)
District 5: Victor J. Bilotta, M.D. (90)
District 6: Thomas D. Bartley, M.D. (90)
District 7: J. Robert Qualey, M.D, (90)
District 8: Donald G. Nikolaus, M.D. (90)
District 9: Walter Lane, M.D. (90)
District 10: Bob Peddy, M.D. (90)
District 11: John B. Adamson, M.D. (90)
District 12: Fred S. Carter, M.D. (90)



Dr. James B. Perry, President-Elect, addresses the House.

District 13: Joseph P. O'Bryan, M.D. (90)
District 14: E. Joan Barice, M.D. (90)
District 15: Peter A. Tomasello, M.D. (90)
District 16: Barbara Drabkin, M.D. (90)
District 17: Chason Wm. Hayes, M.D. (90)
District 18: Sheldon Zane, M.D. (90)
District 19: Norman L. Gottlieb, M.D. (90)



The annual Past Presidents Breakfast is always a highlight. Seated (left to right): Henry J. Babers Jr., M.D., Gainesville (1969); Edward Annis, M.D., Miami, AMA Past President; Joseph C. Von Thron, M.D., Cocoa Beach (1973); Frank C. Coleman, M.D., Tampa, (1984); Jere W. Annis, M.D., Lakeland (1958); Samuel M. Day, M.D., Jacksonville (1964). Standing (left to right): Jack A. MaCris, M.D., St. Petersburg (1976); James T. Cook Jr., M.D., Marianna (1970); H. Phillip Hampton, M.D., Tampa (1965); Richard S. Hodes, M.D., Tampa (1979); Louis C. Murray, M.D., Orlando (1977); J. Lee Dockery, M.D., Gainesville (1983); T. Byron Thames, M.D., Orlando (1980); Sanford A. Mullen, M.D., Jacksonville (1981).



The 1986-87 Florida Medical Association Board of Governors poses for the first time after the final session of the House of Delegates. Seated (left to right): Vice President Kay K. Hanley, M.D., Clearwater; Speaker of the House Guy T. Selander, M.D., Jacksonville; President Elect James G. White, M.D., Ormond Beach; President and Chairman James B. Perry, M.D., Fort Lauderdale; Immediate Past President Luis M. Perez, M.D., Sanford; Treasurer Yank D. Coble Jr., M.D., Jacksonville; Secretary Henry M. Yonge, M.D., Pensacola. Standing: Vice Speaker Arthur L. Eberly Jr., M.D., Lighthouse Point; Past President Frank C. Coleman, M.D., Tampa; A. Fredrick Schild, M.D., Miami; Joseph C. Von Thron, M.D., Cocoa Beach; Gerold L. Schiebler, M.D., Gainesville; Miss Jane A. Daniel, Student Member, Clearwater; Margaret C.S. Skinner, M.D., Miami; Dick L. Van Eldik, M.D., Lake Worth; Paul A. Flaten, M.D., Fort Lauderdale; Calvin W. Martin, M.D., Arcadia; J. Lee Dockery, M.D., Gainesville; Executive Vice President Donald C. Jones, Jacksonville.

Dr. Perry announced the members of the Board of Governors who had been either appointed or elected:

FMA Board of Governors

James B. Perry, M.D., President and Chairman
James G. White, M.D., President-Elect
Kay K. Hanley, M.D., Vice President
Henry M. Yonge, M.D., Secretary
Yank D. Coble Jr., M.D., Treasurer
Luis M. Perez, M.D., Immediate Past President
Frank C. Coleman, M.D., Past President
Guy T. Selander, M.D., Speaker of the House
Arthur L. Eberly J., M.D., Vice Speaker
Joseph C. Von Thron, M.D., AMA-87
Paul A. Flaten, M.D., AL-87
Gerold L. Schiebler, M.D., A-90
Calvin W. Martin, M.D, B-87
Dick L. Van Eldik, M.D., C-89
A. Fredrick Schild, M.D., D-88
Margaret C.S. Skinner, M.D., SBME-87
J. Lee Dockery, M.D., DHRS-87
Keith E. McManus, M.D., Resident Member
Miss Jane A. Daniel, Student Member (UM)

Dr. Selander recognized Dr. Keith E. McManus who thanked the House for electing him Resident Member of the Board of Governors.

Dr. Selander then called Dr. Joseph C. Von Thron to the podium for the benediction.

The 1986 House of Delegates adjourned at 11:00 a.m.

Florida Medical Association, Inc. Officers, Councils and Committees 1986-87

OFFICERS

James B. Perry, M.D., President Ft. Lauderdale
James G. White, M.D., President-Elect Ormond Beach
Kay K. Hanley, M.D., Vice President Clearwater
Henry M. Yonge, M.D., Secretary Pensacola
Yank D. Coble Jr., M.D., Treasurer Jacksonville
Guy T. Selander, M.D., Speaker of House Jacksonville
Arthur L. Eberly Jr., M.D., Vice Speaker Lighthouse Point
Luis M. Perez, M.D., Imm. Past Pres. Sanford
Mr. Donald C. Jones, Exec. Vice Pres. Jacksonville

BOARD OF GOVERNORS

*James B. Perry, M.D., President and Chairman ... Ft. Lauderdale
*James G. White, M.D., President-Elect Ormond Beach
*†Kay K. Hanley, M.D., Vice President Clearwater
*Henry M. Yonge, M.D., Secretary Pensacola
*Yank D. Coble Jr, M.D., Treasurer Jacksonville
*Guy T. Selander, M.D., Speaker of House Jacksonville
*Luis M. Perez, M.D., IPP-88 Sanford
*Frank C. Coleman, M.D., PP-87 Tampa
Paul A. Flaten, M.D., AL-87 Ft. Lauderdale
Gerold L. Schiebler, M.D., A-90 Gainesville
Calvin W. Martin, M.D., B-87 Arcadia
*Dick L. Van Eldik, M.D., C-89 Lake Worth
A. Frederick Schild, M.D., D-88 Miami
Joseph C. Von Thron, M.D., AMA Del.-87 Cocoa Beach
J. Lee Dockery, M.D., DHRS-87 Gainesville
Margaret C. S. Skinner, M.D., SBME-87 Miami
Jane A. Daniel, Med. Student Rep.-87 Miami
Keith McManus, M.D., Res.-88 Orlando

*Executive Committee
†Public Relations Officer

Liaison with Florida Osteopathic Medical Association
Louis C. Murray, M.D. Orlando
Liaison with Florida Bar
James B. Perry, M.D. Ft. Lauderdale
Liaison with FLAMPAC
James G. White, M.D. Ormond Beach
Historian
Clyde M. Collins, M.D. Jacksonville

COMMITTEES OF THE BOARD

COMMITTEE ON BYLAWS

Sanford A. Mullen, M.D., Chairman Jacksonville
James B. Perry, M.D. Ft. Lauderdale
Harold G. Norman Jr., M.D. Coral Gables
Henry M. Yonge, M.D. Pensacola
Martin S. Feigenbaum, M.D. Ormond Beach

SPECIAL COMMITTEE ON ETHICS

Charles J. Kahn, M.D., Chairman Pensacola
Clyde M. Collins, M.D. Jacksonville
Norman M. Kenyon, M.D. Miami
Joseph C. Von Thron, M.D. Cocoa Beach
James B. Perry, M.D. Ft. Lauderdale
Pierre J. Bouis Jr., M.D., Ex Officio Tampa
David H. Smith, Ph.D., USF Tampa
Reverend Vincent Kelly Ft. Lauderdale
James B. Dolan, M.D. Gainesville
William H. Adams, Esq., Advisor Jacksonville
Sen. Kenneth C. Jenne, Advisor Hollywood

COMMITTEE ON MEMBERSHIP DEVELOPMENT

Richard J. Bagby, M.D., Chairman Orlando
Andrea M. Bender, M.D., Resident Miami
Patricia J. Dury, Medical Student Gainesville
Nelito R. Ano, M.D. South Daytona
William L. Bacon, M.D. Miami
W. Dean Steward, M.D. Marianna
Guy T. Selander, M.D. Jacksonville
Scott B. Baker, M.D. Jacksonville

FLORIDA AMA DELEGATES

Joseph C. Von Thron, M.D., Chm., Del. Seat #7 Cocoa Beach
Charles A. Dunn, M.D., Alt. Seat #7 Miami
(Terms expire 12/31/87)
Charles J. Kahn, M.D., Vice Chm., Del. Seat #6 Pensacola
O. William Davenport, M.D., Alt. Seat #6 Miami
(Terms expire 12/31/87)
T. Byron Thames, M.D., Del. Seat #1 Orlando
Daniel L. Seckinger, M.D., Alt. Seat #1 Miami
(Terms expire 12/31/87)
Joseph T. Ostroski, M.D., Del. Seat #2 Miami
James B. Perry, M.D., Del. Seat #2 Ft. Lauderdale
(Terms expire 12/31/88)
Charles K. Donegan, M.D., Del. Seat #3 St. Petersburg
Lee A. Fischer, M.D., Alt. Seat #3 West Palm Beach
(Term expires 12/31/88)
Frank C. Coleman, M.D., Del. Seat #4 Tampa
Eugene G. Peek Jr., M.D., Alt. Seat #4 Ocala
(Term expires 12/31/87)
Richard G. Connar, M.D., Del. Seat #5 Tampa
Harold Norman, M.D., Alt. Seat #5 Miami
(Terms expire 12/31/88)

Louis C. Murray, M.D., Del. Seat #8 Orlando
Alvin E. Smith, M.D., Alt. Seat #8 Ormond Beach
(Terms expire 12/31/87)
Kay K. Hanley, M.D., Del. Seat #9 Clearwater
T. Wallace Hahn, M.D., Alt. Seat #9 Pompano Beach
(Terms expire 12/31/88)
Luis M. Perez, M.D., Del. Seat #10 Sanford
Arthur L. Eberly Jr., M.D., Alt. Seat #10 Lighthouse Pt.
(Terms expire 12/31/88)
Sanford A. Mullen, M.D., Del. Seat #11 Jacksonville
Dick L. Van Eldik, M.D., Alt. Seat #11 Lake Worth
(Terms expire 12/31/88)
J. Lee Dockery, M.D., Del. Seat #12 Gainesville
Henry M. Yonge, M.D., Alt. Seat #12 Pensacola
(Terms expire 12/31/87)

BOARD OF PAST PRESIDENTS

Thad Moseley, M.D., 1974, Chairman Cocoa Beach
Luis M. Perez, M.D., 1985, Secretary Sanford
Jere W. Annis, M.D., 1958 Lakeland
Leo M. Wachtel, M.D., 1960 Jacksonville
Samuel M. Day, M.D., 1964 Jacksonville
H. Phillip Hampton, M.D., 1965 Tampa
George S. Palmer, M.D.,1966 Tallahassee
W. Dean Steward, M.D., 1967 Marianna
Henry J. Babers Jr., M.D., 1969 Gainesville
James T. Cook Jr., M.D., 1970 Marianna
Floyd K. Hurt, M.D., 1971 Jacksonville
William J. Dean, M.D., 1972 St. Petersburg
Joseph C. Von Thron, M.D., 1973 Cocoa Beach
Vernon B. Astler, M.D., 1975 Boynton Beach
Jack A. MaCris, M.D., 1976 St. Petersburg
Louis C. Murray, M.D., 1977 Orlando
O. William Davenport, M.D., 1978 Miami
Richard S. Hodes, M.D., 1979 Tampa
T. Byron Thames, M.D., 1980 Orlando
Sanford A. Mullen, M.D., 1981 Jacksonville
Robert E. Windom, M.D., 1982 Sarasota
J. Lee Dockery, M.D., 1983 Gainesville
Frank C. Coleman, M.D., 1984 Tampa

AD HOC COMMITTEE ON PREPAID PLANS

Frank C. Coleman, M.D., Chairman Tampa
Richard S. Hodes, M.D. Tampa
Charles P. Hayes Jr., M.D. Jacksonville
Paul T. Baroco, M.D. Pensacola
Victor J. Bilotta, M.D. Altamonte Springs

COMMITTEE ON PUBLIC RELATIONS AND COMMUNICATIONS

Kay K. Hanley, M.D., Chairman Clearwater

COUNCIL OF COUNTY MEDICAL SOCIETY OFFICERS

Bruce W. Weissman, Chairman Miami

COUNCIL ON LEGISLATION

Louis C. Murray, M.D., Chairman Orlando

NATIONAL LEGISLATION

Robert C. Mumby, M.D. Orlando
C. Stanton Green, M.D. Jacksonville
Donald G. Nikolaus, M.D. Dunedin
Gerold L. Schiebler, M.D. Gainesville
Lee A. Fischer, M.D. West Palm Beach
Henry M. Clayman, M.D. Miami Beach
William I. Roth, M.D. Miami
Frank C. Coleman, M.D., Chairman Tampa
Joe B. Harbison, M.D. Panama City
James G. White, M.D. Ormond Beach
William J. Broussard, M.D. Melbourne
William F. Eckbert, M.D. Winter Park
Warren Lindau, M.D. Miami
H. Quillian Jones Jr., M.D. Fort Myers
James B. Perry, M.D. Ft. Lauderdale
John W. Glotfelty, M.D. Lakeland
V. A. Marks, M.D. Palm Beach Gardens
Stanley I. Margulies, M.D. Hollywood
Laurie L. Dozier Jr., M.D. Tallahassee

STATE LEGISLATION

T. Wallace Hahn, M.D., Chairman Pompano Beach
Mathis L. Becker, M.D. Plantation
Thomas P. Wood, M.D. Tallahassee
Eric F. Geiger, M.D. Pensacola
Virgil A. Ponzoli Jr., M.D. Naples
Richard G. Spurlock, M.D. Tampa
Alvin E. Smith, M.D. Ormond Beach
Marc D. Kaye, M.D. Jacksonville
Cecil B. Wilson, M.D. Winter Park
William J. Romanos Jr., M.D. Palm Beach Gardens
Robert E. Boyett, M.D. Miami
Harold G. Norman, M.D. Miami
Robert C. Mumby, M.D. Orlando
T. M. "Dan" Daniel, M.D. Clearwater
Mrs. J. H. (Nancy) Corwin Jacksonville
Rep. David L. Thomas, M.D. Port Charlotte
Sen. William G. Myers, M.D. Tequesta

COUNCIL ON MEDICAL ECONOMICS

Charles P. Hayes Jr., M.D., Chairman Jacksonville

COMMITTEE ON HEALTH CARE FINANCING AND ALTERNATIVE DELIVERY MECHANISMS

William J. Garoni Jr., M.D., Chairman Jacksonville
Jack W. MacDonald, M.D. Tallahassee
Paul T. Baroco, M.D. Pensacola
Robert J. Brueck, M.D. Ft. Myers
Richard F. Ott, M.D. Ft. Lauderdale
Gerald L. Stoker, M.D. Tampa
Richard M. Garcia, M.D. Winter Haven
Thomas R. Busard, M.D. Bradenton
Lee A. Fischer, M.D. West Palm Beach

COMMITTEE ON GOVERNMENT PROGRAMS

Donald G. Nikolaus, M.D., Chairman Dunedin
James K. Conn, M.D. Tallahassee
Ernest G. Sayfie, M.D. Hollywood
E. Charlton Prather, M.D. Tallahassee
Hector R. Mendez, M.D. Orlando
Charles Konigsberg, M.D. Ft. Lauderdale
Wilbert L. Dawkins, M.D. Jacksonville
Patrick J. O'Malley, M.D. Palatka

COMMITTEE ON RELATIVE VALUE STUDIES

Jimmie D. Moore, M.D., Chairman Orlando
Charles K. Donegan, M.D., Vice Chairman St. Petersburg
Benjamin A. Johnson, M.D. Jacksonville
James A. Jordan, M.D. Ft. Lauderdale
Joel W. Mattison, M.D. Tampa
Herbert D. Kerman, M.D. Daytona Beach
Daniel L. Seckinger, M.D. Miami
Richard W. Snodgrass, M.D. Daytona Beach
George A. Richard, M.D. Gainesville
William H. Meyer Jr., M.D. Ft. Pierce

COMMITTEE ON WORKER'S COMPENSATION

Howard A. Kurzner, M.D., Chairman Miami
Benjamin A. Johnson, M.D. Jacksonville
Calvin R. Peters, M.D. Orlando
Howard P. Hogshead, M.D. Jacksonville
Lawrence S. Cohen, M.D. Tampa
McKinley Cheshire, M.D. West Palm Beach

COMMITTEE ON INDIGENT CARE

Charles B. McIntosh, M.D., Chairman Jacksonville
Charles P. Hayes Jr., M.D., Vice Chairman Jacksonville
Jack W. MacDonald, M.D. Tallahassee
James K. Conn, M.D. Tallahassee
Donald G. Nikolaus, M.D. Dunedin
John F. McGarry, M.D. Orlando
Husman Khan, M.D. Lauderhill
Richard S. Hodes, M.D. Tampa
T.M. (Dan) Daniel, M.D. Clearwater
Jacques R. Caldwell, M.D. Daytona Beach
John McBryde, Advisory Orlando
Kerry Kilpatrick, Ph.D., Advisory Gainesville
James B. Perry, M.D., Board Liaison Ft. Lauderdale
Sen. George Stuart Jr., Advisor Orlando
Rep. Alzo J. Reddick, Advisor Orlando

COMMITTEE ON PEER REVIEW ORGANIZATIONS (PRO)

Arthur L. Eberly Jr., M.D., Chairman Lighthouse Point
Paul J. Popovich, M.D. Melbourne
A. Raymond Brooker Jr., M.D. Tampa
Charles A. Dunn, M.D. Miami
Alan J. Yesner, M.D. Ft. Lauderdale
Thomas E. McKell, M.D., Liaison Member Tampa
Paul W. Oberdorfer, M.D. Jacksonville
Robert H. Hux, M.D. Leesburg
Steven S. Spore, M.D. Deland
Thomas D. Bartley, M.D. Gainseville

COUNCIL ON MEDICAL SERVICES

Joseph T. Ostroski, M.D., Chairman Miami

EMERGENCY MEDICAL SERVICES

H. Quillian Jones Jr., M.D., Chairman Ft. Myers
Steven J. Dresnick, M.D. Coral Gables
H. Wayne Lee, M.D. Ft. Lauderdale
Luis Quintero, M.D. Titusville
Alfred G. Smith, M.D. Miami
H. Warner Webb, M.D. Jacksonville
David J. Kreis Jr., M.D. Miami
Jack B. Yaffa, M.D. Miami
James L. Talbert, M.D. Gainesville
Robert A. Gay, M.D. Longwood

COMMITTEE ON AGING

Eric A. Pfeiffer, M.D., Chairman Tampa
George J. Caranasos, M.D. Gainesville
Joseph Harris, M.D. Miami Beach
James N. Sussex, M.D. Miami
Mrs. Fred P. (Anne) Swing Charlotte Harbor
James G. White, M.D., Board Liaison Member Ormond Beach

COMMITTEE ON SUBSTANCE ABUSE

Joseph H. Deatsch, M.D., Chairman Jacksonville
John S. Flint, M.D. St. Petersburg
John C. Eustace, M.D. Miami Beach
Donn L. Smith, M.D. Tampa
Mrs. S. B. (Priscilla) Gerber Winter Haven
William H. Fergus, M.D. Plantation
E. Joan Barice, M.D. Singer Island
James A. Alford, M.D. Tallahassee
Roger A. Goetz, M.D., Advisory Member Jacksonville
Joseph E. Dorsey, M.D. Hollywood

COMMITTEE ON SCHOOL HEALTH

Linda A. Marraccini, M.D., Chairman South Miami
Bernard Kimmel, M.D., Vice Chairman West Palm Beach
Richard J. Boothby, M.D. Jacksonville
James J. Townsend, M.D. Jacksonville
J. Patrick Hanley, M.D. Clearwater
F. Edwards Rushton, M.D. Tallahassee
Roger K. Schwartzberg, D.O. Seminole
Annette C. Barnes, M.D. Bartow

COMMITTEE ON PUBLIC HEALTH

Donald S. Kwalick, M.D., Chairman Tampa
June M. Atkinson, M.D., Vice Chairman Tavares
Patricia C. Cowdery, M.D. Jacksonville
R. Edward Dodge Jr., M.D. Inverness
Jorge DeJu, M.D. Longwood
E. Charlton Prather, M.D. Tallahassee
James T. Howell, M.D. West Palm Beach
Alzo J. Reddick, House Advisor Orlando
George L. Stuart Jr., Senate Advisor Orlando
E. Joan Barice, M.D. Singer Island
George A. Gant, M.D. Kissimmee
Clarence L. Brumback, M.D. West Palm Beach

COMMITTEE ON VOLUNTARY HEALTH AGENCIES AND ALLIED HEALTH

William W. Thompson, M.D., Chairman Ft. Walton Beach
William A. Sodeman Jr., M.D. Tampa
Jay S. Skyler, M.D. Miami

George A. Gant, M.D. Kissimmee
Steven S. Spore, M.D. Deland
Marianni M. La Rue, M.D. Winter Park
Mrs. J. B. (Peg) Perry Ft. Lauderdale

COUNCIL ON SCIENTIFIC ACTIVITIES

Pierre J. Bouis Jr., M.D., Chairman Tampa

COMMITTEE ON MEDICAL EDUCATION

Orris O. Rollie, M.D., Chairman Orlando
George A. Bishopric, M.D. Sarasota
David R. Arrowsmith, M.D. Ft. Walton Beach
Charles W. Hilton, M.D. Jacksonville
Ira B. Harrison, M.D. Tallahassee
Anthony P. Garritano, M.D. Largo
William B. Deal, M.D., Dean Gainesville
Donn L. Smith, M.D., Dean Tampa
Bernard J. Fogel, M.D., Dean Miami

COMMITTEE ON SCIENTIFIC PUBLICATIONS

R. G. Lacsamana, M.D., Chm., Editor Daytona Beach
Gerold L. Schiebler, M.D., Liaison Bd of Gov. Gainesville
Lee A. Fischer, M.D. West Palm Beach
Henry L. Harrell Jr., M.D. Ocala
F. Norman Vickers, M.D. Pensacola
Frank C. Coleman, M.D. Tampa
James K. Conn, M.D. Tallahassee
Kay K. Hanley, M.D. Clearwater
Robert E. McCammon, M.D. Tampa
Daniel B. Nunn, M.D. Jacksonville
Clyde M. Collins, M.D. Jacksonville
Richard J. Feinstein, M.D. Miami
Edward Pedrero Jr., M.D., Ph.D. Tampa
E. Charlton Prather, M.D. Tallahassee
William M. Straight, M.D. Coral Gables
Pierre J. Bouis Jr., M.D. Tampa
H. Frank Farmer, M.D., Ph.D. New Smyrna Beach
Jacques Caldwell, M.D. Daytona Beach

COUNCIL ON HOSPITAL MEDICAL STAFFS

T. M. "Dan" Daniel, M.D., Chairman Clearwater
Richard W. Cunningham, M.D. Gainesville
Marc S. Freedman, M.D. Hudson
George P. Thomas, M.D. Tampa
Richard W. Snodgrass, M.D. Daytona Beach
Joseph Harris, M.D. Miami Beach
Robert P. Johnson, M.D. Tallahassee
Jack B. Yaffa, M.D. Miami
Hugh K. McCrystal, M.D. Vero Beach

COUNCIL ON SPECIALTY MEDICINE

Thomas D. Bartley, M.D., Chairman Gainesville

Florida Allergy and Immunology Society
Melvin Newman, M.D. Jacksonville
Florida Society of Anesthesiologists
Jimmie D. Moore, M.D. Orlando
Florida Chapter, American College of Chest Physicians
W. Michael Alberts, M.D. Tampa
Florida Society of Colon and Rectal Surgeons
Harvey A. Shub, M.D. Orlando
Florida Society of Dermatology
Clifford Lober, M.D. Altamonte Springs
Florida Chapter, American College of Emergency Physicians
Fredric C. Wurtzel, M.D. Maitland
Florida Endocrine Society
Amid Habib, M.D. Altamonte Springs
Florida Academy of Family Physicians
Charles A. Dunn, M.D. Miami
Florida Gastroenterologic Society
Jan S. Hirschfield, M.D. Clearwater
Florida Society of Internal Medicine
Fred S. Carter, M.D. Jensen Beach
Florida Society of Neonatal Perinatologists
Thomas Chiu, M.D. Tampa
Florida Society of Nephrology
Thomas C. Marbury, M.D. Orlando
Florida Society of Neurology
John S. Scott, M.D. Orlando
Florida Neurosurgical Society
David L. Lane, M.D. Ft. Lauderdale
Florida Association of Nuclear Physicians
Warren R. Janowitz, M.D. Miami Beach
Florida Obstetric and Gynecologic Society
Robert T. Hoover, M.D. Winter Park
Florida Occupational Medical Association
R. Than Myint, M.D. Tampa
Florida Society of Clinical Oncologists
Alan H. Porter, M.D. Sarasota
Florida Society of Ophthalmology
Maurice M. Berger, M.D. Leesburg
Florida Orthopedic Society
William J. Hutchison, M.D. Tallahassee
Florida Society of Otolaryngology — Head and Neck Surgery
Robert K. Middlekauff, M.D. Jacksonville
Florida Society of Pathologists
Joseph H. Keffer, M.D. Miami Beach
Florida Chapter, American Academy of Pediatrics and Florida Pediatric Society
George A. Richard, M.D. Gainesville
Florida Association of Pediatric Cardiologists
Ira H. Gessner, M.D. Gainesville
Florida Association of Pediatric Surgeons
Ronald F. David, M.D. Orlando
Florida Society of Physical Medicine and Rehabilitation
Richard A. Chidsey, M.D. Jupiter
Florida Region, American College of Physicians
David A. Giordano, M.D. Sarasota
Florida Society of Plastic and Reconstructive Surgery
Alan S. Rapperport, M.D. Plantation Key
Florida Society for Preventive Medicine
E. Charlton Prather, M.D. Tallahassee
Council of Florida District Branches, American Psychiatric Association
McKinley Cheshire, M.D. West Palm Beach
Florida Radiological Society
W. Thomas Hawkins, M.D. Gainesville
Florida Society of Rheumatology
Louis M. Sales, M.D. Jacksonville
Florida Chapter, American College of Surgeons
John C. Fletcher, M.D. Tampa
Florida Association of General Surgeons
Theron T. Knight, M.D. Lehigh Acres
Florida State Surgical Division, International College of Surgeons
Robert H. Hux, M.D. Leesburg
Florida Society of Thoracic and Cardiovascular Surgeons
Franklin G. Norris, M.D. Orlando

Florida Thoracic Society
Robert C. Snyder, M.D. Orlando
Florida Urological Society
Manuel J. Coto, M.D. Orlando

JUDICIAL COUNCIL

Joseph H. Davis, M.D., D-87, Chairman Miami
O. Frank Agee, M.D., A-90 Gainesville
Kenneth C. Kiehl, M.D., B-89 Sarasota
Robert J. Brennan, M.D., C-88 Ft. Lauderdale
Maurice H. Laszlo, M.D., AL-91 N. Miami Beach

MEMBERSHIP AND DISCIPLINE

District 1 - James T. Cook III, M.D., 87 Panama City
Robert C. Palmer, M.D., 88 Pensacola
Rufus Thames, M.D., 89 Milton
Lelis L. Hale Jr., M.D., 90 Ft. Walton Beach

District 2 - Robert P. Johnson, M.D., 87 Tallahassee
James T. Cook Jr., M.D., 88 Marianna
Herbert E. Brooks, M.D., 89 Bonifay
James K. Conn, M.D., 90 Tallahassee

District 3 - Hugh A. Carithers, M.D., 87 Jacksonville
John A. Rush, M.D., 88 Jacksonville
Joe C. Ebbinghouse, M.D., 89 Jacksonville
Samuel J. Alford Jr., M.D., 90 Jacksonville

District 4 - Charles E. Barrineau, M.D., 87 Palatka
Richard W. Snodgrass, M.D., 88 Daytona Beach
Bruce R. Witten, M.D., 89 St. Augustine
H. Frank Farmer, M.D., 90 New Smyrna Beach

District 5 - Calvin R. Peters, M.D., 87 Orlando
Clarence M. Gilbert, M.D., 88 Orlando
James E. Quinn, M.D., 89 Sanford
Victor J. Bilotta, M.D., 90 Altamonte Springs

District 6 - W. Thomas Hawkins, M.D., 87 Gainesville
David A. Johnson, M.D., 88 Zephyrhills
Wilburn R. Jenkins, M.D.,89 Inverness
Thomas D. Bartley, M.D., 90 Gainesville

District 7 - Linus W. Hewit, M.D., 87 Tampa
William B. Hopkins, M.D., 88 Tampa
Jeff W. Harris, M.D., 89 Tampa
J. Robert Qualey, M.D., 90 Tampa

District 8 - William E. Hale, M.D., 87 Dunedin
John T. Karaphillis, M.D., 88 Clearwater
Royce Hobby, M.D., 89 St. Petersburg
Donald G. Nikolaus, M.D., 90 Dunedin

District 9 - Paul G. Winquist, M.D., 87 New Pt. Richey
Joseph P. Levine, M.D., 88 Tampa
Bettie R. Drake, M.D., 89 Tampa
Walter Lane, M.D., 90 Tampa

District 10 - William Allen Boyce, M.D., 87 Bradenton
Wiley E. Koon, M.D., 88 Winter Haven
James D. Morgan, M.D., 89 Winter Haven
Bob Peddy, M.D., 90 Lakeland

District 11 - David Tingle, M.D., 87 Gainesville
John O. Rao, M.D., 88 Kissimmee
Enoch J. Vann, M.D., 89 Vero Beach
John B. Adamson, M.D. 90 Cocoa Beach

District 12 - V. A. Marks, M.D., 87 Palm Beach Gardens
Robert Burger, M.D., 88 Lake Worth
Reginald J. Stambaugh, M.D., 89 W. Palm Bch.
Fred S. Carter, M.D., 90 Jensen Beach

District 13 - Richard C. Rehmeyer, M.D., 87 Sarasota
David L. Thomas, M.D., 88 Venice
Martin F. Mihm, M.D., 89 Sarasota
Joseph P. O'Bryan, M.D., 90 Ft. Myers

District 14 - Lee A. Fischer, M.D., 87 West Palm Beach
William J. Romanos Jr., M.D., 88 N. Palm Bch.
James F. Smith, M.D., 89 West Palm Beach
E. Joan Barice, M.D., 90 Singer Island

District 15 - Stanley S. Goodman, M.D., 87 Plantation
Wayne G. Riskin, M.D., 88 Hollywood
Robert J. Brennan, M.D., 89 Ft. Lauderdale
Peter A. Tomasello, M.D., 90 Plantation

District 16 - William C. Hartley, M.D., 87 Hollywood
Nestor C. Guaty, M.D., 88 Miami
Jose F. Landa-Gutierrez, M.D., 89 Miami
Barbara Drabkin, M.D., 90 Hallandale

District 17 - Charles A. Monnin Jr., M.D., 87 Hialeah
Richard C. Clay, M.D.,88 Miami
Maurice H. Laszlo, M.D., 89 N. Miami Beach
Chason W. Hayes, M.D., 90 Miami Shores

District 18 - Everett Shocket, M.D., 87 Miami Beach
Jerome Benson, M.D., 88 Miami Beach
Richard M. Fleming, M.D., 89 Miami Beach
Sheldon Zane, M.D., 90 N. Miami Beach

District 19 - John D. White, M.D., 87 Tavernier
Rufus K. Broadaway, M.D., 88 Miami
Linda Ann Marraccini, M.D., 89 South Miami
Norman L. Gottlieb, M.D., 90 Coconut Grove

FLORIDA MEDICAL FOUNDATION

James G. White, M.D., President Ormond Beach
Dick L. Van Eldik, M.D., Vice President Lake Worth
Henry M. Yonge, M.D., Vice President Pensacola
Kay K. Hanley, M.D., Vice President Clearwater
Yank D. Coble Jr., M.D., Secretary-Treasurer Jacksonville

CONTINUING MEDICAL EDUCATION

Robert E. Cline, M.D., Chairman Ft. Lauderdale
James T. Cook III, M.D., Vice Chm. Panama City
Charles E. Phillips, M.D. Orange Park
R. Steven White, M.D. Daytona Beach
Arvey I. Rogers, M.D. Miami
Yank D. Coble Jr., M.D. Jacksonville
Alvin E. Smith, M.D. Daytona Beach

PEER MEDICAL UTILIZATION REVIEW

Charles B. Mutter, M.D., Chairman Miami
Peter A. Tomasello, M.D., Vice Chm. Plantation
Kenneth C. Kiehl, M.D. Sarasota
John A. Dyal, M.D. Perry
Frank B. Hodnette, M.D. Pensacola
John T. Karaphillis, M.D. Clearwater
Milton E. Lesser, M.D. Miami Beach
Willard E. Manry, M.D. Lake Wales
Elwin G. Neal, M.D. Miami Shores
Benjamin C. Olliff, M.D. Jacksonville
William A. Alonso, M.D. Tampa

IMPAIRED PHYSICIANS

Guy T. Selander, M.D., Chairman Jacksonville
Harold L. Ishler Jr., M.D. Clearwater
Arvey I. Rogers, M.D. Miami
Dolores A. Morgan, M.D. Miami Beach
Roger A. Goetz, M.D., Advisory Member Jacksonville
H. Larry Gore, D.V.M., Fla. Vet. Med. Assn. Orlando
Lynn R. Hankes, M.D. Miami
George S. Palmer, M.D. Tallahassee

FLORIDA MEDICAL ASSOCIATION AUXILIARY

Mrs. V. A. (Susan) Marks, President N. Palm Beach
Mrs. Rex (Betty) Orr, President-Elect St. Petersburg
Mrs. Arthur L. (Jane) Eberly Jr., First Vice Pres. Lighthouse Pt.
Mrs. Joseph (Bea) George, Secretary Miami
Mrs. Carl (Tommy Jean) Redderson, Treasurer St. Petersburg

FLORIDA MEDICAL POLITICAL ACTION COMMITTEE

Board of Directors

James G. White, M.D., President Ormond Beach
Frank C. Coleman, M.D., Imm. Past President Tampa
Vice President Vacant
Carlos G. Llanes, M.D., Secretary Miami
Louis C. Murray, M.D., Treasurer Orlando
Luis M. Perez, M.D. Sanford
H. Quillian Jones Jr., M.D. Fort Myers
Juan S. A. Wester, M.D. Hollywood
Brian P. Gibbons, M.D. Cocoa Beach
Dick L. Van Eldik, M.D. Lake Worth
Warren Lindau, M.D. Miami
Frank R. Wilkerson Jr., M.D. Ocala
William W. Thompson, M.D. Ft. Walton Beach
James W. Bridges, M.D. Miami
Richard S. Hodes, M.D. Tampa
James L. West, M.D. St. Petersburg
Mrs. James H. (Nancy) Corwin Neptune Beach
T. M. "Dan" Daniel, M.D. Clearwater
Mrs. Arthur L. (Jane) Eberly Jr. Lighthouse Point
Mrs. B. David (Edie) Epstein Key Biscayne
John W. Glotfelty, M.D. Lakeland
Kay K. Hanley, M.D. Clearwater
Stanley I. Margulies, M.D. Hollywood
Terence P. McCoy, M.D. Tallahassee
Richard B. Moore, M.D. West Palm Beach
Donald G. Nikolaus, M.D. Dunedin
Kenneth C. Kiehl, M.D. Sarasota
Donald Ames, M.D. Vero Beach
William I. Roth, M.D. Miami
Michael J. Pickering, M.D. Tampa
T. W. Hahn, M.D. Pompano Beach
Alvin E. Smith, M.D. Ormond Beach
Mrs. Donald G. (Jean) Nikolaus Palm Harbor
Mrs. V. A. (Susan) Marks Palm Beach Gardens
Mr. Donald C. Jones, Assistant Treasurer Jacksonville

FLORIDA PHYSICIANS ASSOCIATION, INC.

Charles J. Kahn, M.D., President Pensacola
John A. Dyal, M.D., Vice President Perry
Miguel Figueroa, M.D. N. Miami Beach
Warren M. Barrett, M.D., Treasurer Jacksonville
David T. Overbey, M.D., Imm. Past President St. Petersburg
James B. Perry, M.D., FMA Representative Ft. Lauderdale
Frank C. Coleman, M.D., FMA Representative Tampa
Luis M. Perez, M.D., FMA Representative Sanford
William W. Thompson, M.D., FLAMPAC Rep. ... Ft. Walton Beach

CERTIFIED PUBLIC ACCOUNTANTS

Harbeson Beckerleg & Fletcher Jacksonville

GENERAL COUNSEL

John E. Thrasher, Esq. General Counsel
Donald W. Weidner, Esq. Associate General Counsel

The FMA in cooperation with the AMA puts current information at your fingertips!



"MINET gives me up-to-date medical information in seconds . . . which means more time for patient care."

Join a growing number of your colleagues who are making more productive use of their time by subscribing to MINET® —the Medical Information Network developed by GTE Telenet.

With a personal computer or data terminal and telephone, you have around-the-clock access to a vast electronic library of clinical and practice-related information—from your home, office, or hospital. Information that could take hours or even days to track down through traditional channels can now be retrieved in minutes.

You'll have more time for patient care when you plug into the large variety of on-line American Medical Association databases that include:

—drug and disease information
—clinical abstracts
—administrative and medical-practice information
—Continuing Medical Education courses
—Associated Press (AP) medical news

With MINET's electronic mail service, Med/Mail® , you can receive information from such sources as the Centers for Disease Control, the Office of the U.S. Surgeon General, and the JFK Institute.

In addition, MINET brings you PHYCOM® , an advertiser-supported service that links you and leading pharmaceutical companies.

The FMA serves as the official GTE distributor in Florida for MINET and can also assist you in obtaining all necessary equipment for gaining access to the system at the lowest possible price.

GTE Telenet
Medical Information Network

GTE

**FOR SUBSCRIPTION AND EQUIPMENT INFORMATION PLEASE CONTACT THE FLORIDA MEDICAL ASSOCIATION, INC.
P.O. BOX 2411, JACKSONVILLE, FL 32203
TELEPHONE 904/356-1571**

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

University of Miami School of Medicine — Department of Medicine
Twenty-Second Annual Postgraduate Course

"INTERNAL MEDICINE 1987"
March 1-6, 1987
Sheraton Bal Harbour Hotel — Bar Harbour, Florida

The objective of this course, the twenty-second in its series, is to provide an annual updating of the most useful recent advances in the diagnosis and management of internal medical disorders as they are encountered by primary care physicians and practicing specialists. A synopsis and self-assessment questionnaire will be provided.
A distinguished guest faculty will present "State of the Art Lectures" and conduct panel discusions.

Guest Faculty

Robert A. Good, M.D.
Professor and Chairman
Department of Pediatrics
University of South Florida
St. Petersburg, Florida

Daniel J. McCarty, M.D.
Will and Cava Ross
Professor and Chairman
Department of Medicine
Medical College of Wisconsin
Milwaukee, Wisconsin

Kenneth M. Moser, M.D.
Professor of Medicine
University of California
San Diego, California

Robert G. Narins, M.D.
Professor of Medicine
Temple University School
of Medicine
Philadelphia, Pennsylvania

HIGHLIGHTS

SPECIAL SYMPOSIUM ON "AIDS"
An experienced faculty will discuss the latest developments of the Acquired Immunodeficiency Syndrome.

MEET THE FACULTY SESSIONS
Small group conferences in which selected topics in internal medicine will be presented, followed by open discussions.

ACCREDITATION
Supervised CME Activities 33 Hours Credit
"As an organization accredited for continuing medical education, the University of Miami School of Medicine designates this continuing medical activity as meeting the criteria for 33 credit hours in Category I of the Physician's Recognition Award of the American Medical Association."
This Program has been reviewed and is acceptable for 33 Prescribed hours by the American Academy of Family Physicians.

PICTORIAL QUIZ
Our well-established teaching method will cover all fields of internal medicine and will be available throughout the meeting.

EXHIBITS
Selected Scientific and Technical Exhibits will be on display.

VIDEOTAPE SYMPOSIUMS
A large TV screen will show selected subjects during the evenings.

HOTEL ATTRACTIONS
The Sheraton Bal Harbour is located directly on the ocean with 600 feet of private beach, an olympic-sized salt water pool and a salt water indoor pool, and across the street from the exclusive Bal Harbour Shops (Saks Fifth Avenue, Neiman-Marcus, Bonwit Teller — 100 shops in all). Tours, golf, tennis, fishing may be arranged through the hotel.

SOCIAL ATTRACTIONS
A varied program for spouses and children will be offered daily.

Registration: $500/Physician, $350/Physician in Training (a letter from Chief of Service must accompany registration)

For Registration and Information Write: J. S. Bocles, M.D., Department of Medicine (R760), University of Miami School of Medicine, P.O. Box 016760, Miami, FL 33101, (305) 547-6063.

Physician contribution to indigent care

The experience of Volusia County

The Florida indigent medical care program has always been one of the most stingy in the nation. The extant system is scattered among several federal and state agencies and lacks coordination. The Medicaid program is disgraceful and pockmarked by rude and disinterested minions who seem intent upon blocking access of the poor to medical care rather than sincerely aiding them. Today's medically indigent must sedulously pick their way through the chaotic residues of the government aid programs. Many individuals stumble, fall, fail and relinquish the quest for care; only when life threatening or terminal conditions intervene do they obtain medical help — usually by presenting themselves in a desperate condition to a hospital emergency room.

Thirty years ago the care of the indigent was assumed by the local physicians and local hospital. Physicians usually donated their services by working in clinics and by covering the emergency rooms on a rotational basis throughout the month and the hospital was reimbursed partially by taxes and contributions of the local citizenry. Academic centers were willing to assume the diagnostic work up and treatment of the more seriously ill and sustained their reputations and attained patients for their teaching programs by servicing the indigent patients. The innards of the teaching hospitals and indigent wards were not luxurious but they were very functional and efficient. Federal government programs introduced during the age of Kennedy, Johnson, and Galbraith usurped the local responsibility for indigent care and transferred it to the remote canton of Washington, D.C. Layers of bureaucracy and regulations were daubed onto the programs and the ultimate devolution of the system with time resembled a post-Modern gouache that is utterly devoid of any trace of reality and utility. Of course, the cutbacks in indigent care during the past six years have exacerbated and multiplied the frustrations of the system.

The state of Florida has acknowledged its indigent care deficiencies and has legislatively attempted to initiate corrective measures. In 1983 the Health Care Responsibility Act transferred responsibility for indigent care back to the counties within the state. The 1984 legislature mandated and funded a study of indigent care by hospitals within the state. The report of the results of that study were published in March of this year.[1] The results estimated that Florida hospitals contributed $283,000,000 of uncompensated indigent care during 1985 (this estimate was derived from a survey which included 202 of the 227 community hospitals within the state).

The State University Study of Indigent Care did not acknowledge or address the large contribution that individual physicians make to the medical care of the needy. This contribution not only encompasses physician time but also includes the costs of medications that physicians dispense (such as intramuscular or intravenous medications) within their offices and the costs of laboratory tests and x-rays which they order and for which they pay.

Unfortunately studies of the extent of physician contribution to indigent care in the 1980s are not available. For this reason the Volusia County Medical Society designed and conducted a survey among its own members to ascertain an approximation of the indigent care burden that doctors assume. The survey indicates that the average doctor in Volusia County furnishes more than $27,000 annually to the medical care of the poor. If this sum can be legitimately extrapolated to the 20,000 practicing physicians in the state then the total physician beneficence to the Florida indigent exceeds $540,000,000 per year — an amount over twice that contributed by the state hospitals.

Table 1. — Professional Profile of Survey Respondents by Specialty.

Specialty	No. Respondents	No. in Practice	% Resp.
Pediatrics	5	13	31
Int. Med. (Gen)	7	26	27
Int. Med. (Ssp)	9	42	21
Fam. Practice	13	52	25
Psychiatry	2	10	20
Anesthesiology	5	11	45
OB-GYN	5	19	26
Urology	6	11	55
Gen. Surg.	6	20	30
Surg. (Ssp)	10	20	50
Orthopedics	11	20	55
Ophthalmology	7	15	47
Total	86	259	33%

Ssp: Subspecialty. Int. Med. (Ssp) includes gastroenterology, rheumatology, allergy, oncology, neurology, endocrinology, cardiology, and pulmonary medicine. Surg. Ssp. includes neurosurgery, plastic surgery, ENT, and cardiovascular surgery.

The methodology of the study was simple. A questionnaire was mailed to each physician or physician group. The doctors were asked to list the amount of free care given to indigent patients during the previous year and the amount of total uncollectable charges they experienced during the year. The differentiation between total bad debts and the amounts written off for indigent care is obviously an important distinction. If a physician's accounting system did not provide these data then the doctor was asked to make an estimate from the experience of a month such as April, 1986. The office manager was asked to review the records of the patients, distinguish the indigent from non-indigent bad debt, and to make an annual estimate by extending this month's results. April was suggested since it is a reasonable average month that is not distorted by the heavy influx of tourists during the winter nor the efflux of the local population during the summer. The questionnaire requested other information which might be useful in the design of the state indigent care program that is being considered at present. Doctors were asked to identify problems with the current system, problems that were inherent to their own specialty and recommendations that they would make to the design of an indigent care system. Each questionnaire asked if the physician would see indigents in the office, or, if not in the office, in a clinic setting. They were asked if they would see indigents if the liability of medical malpractice was removed or curtailed; whether HMOs should be made responsible for indigent care (since HMOs remove paying patients from the medical care system that is used to fund indigent care rendered by doctors), and to give suggestions for financing indigent health care.

Data on the dollar volume of indigent care were collected from 86 of the 259 (33%) active medical society members (Table 1). Each specialty was fairly represented; the psychiatrists had the lowest percentage of responders (20%); the orthopedic surgeons and urologists had the highest (55%). These differences are well within the 95% confidence limits expected from the sample size and do not distort the figures significantly from a statistical nature.

Total uncompensated care for responding physicians was $4,222,480 (Table 2). The mean level of uncompensated care was $49,099 (with a standard deviation of $58,432).

Indigent care accounted for 56% of the total uncollectable patient charges. The amount of unreimbursed indigent care varied from $800 to $170,000 with a mean of $27,300 and a standard deviation of $30,032. The median for the range was $17,461 (i.e., half the responding physicians contributed less and half more than this amount).

General internists contributed the least amount of free care per doctor respondent (mean = $6,350). The neurosurgeon population in the county is small and thus their results were peremptorily incorporated into the "surgical subspecialists" group (which also includes cardiovascular, ENT, and plastic surgeons). The neurosurgeons contributed more indigent care per doctor ($113,000) than any other specialty.

If these data are representative of the Volusia County physicians (and there is no reason to suspect that it might not be) then the doctors of the medical society provide over $7,000,000 per year of indigent health care for which they receive no compensation. Figures obtained from the American Medical Association indicate that the average southeastern United States physician earned $106,700 during 1983.[2] This amount has not changed significantly (and probably has declined) in the past two years. Therefore, the average physician who responded to this survey is contributing an amount of services and supplies to the indigent that is equivalent to over one quarter of his annual income.

Some physicians who practice in the county are not members of the medical society. If the nonmembers were included in the data, then physicians in the county probably donate in excess of $8,000,000 of free care per year to the local indigent population.

Physician services (excluding dental services) account for 20% and the hospital services over 65% of the national health care dollar. When it comes to uncompensated care for indigents within Volusia County, the doctors contribute a greater sum ($7,000,000) of uncompensated care than do the county hospitals (approximately $4,500,000). Doctors

Table 2. — Annual Dollar Amounts of Total Uncompensated Care and Uncompensated Indigent Care by Specialty.

		$ Total Uncompensated Care			$ Indigent Care		
Spec.	No.	$ Total	Mean	Std. Dev.	$ Total	Mean	Std. Dev.
Ped.	5	149,289	29,858	10,505	108,685	21,737	8,867
IM	7	78,680	11,240	8,240	44,450	6,350	5,990
IM Ssp	9	416,457	46,273	23,632	269,006	29,889	24,057
GP-FP	13	281,140	21,626	23,996	150,590	11,583	14,773
Psych	2	43,320	21,660	na	14,385	7,193	na
Anes	5	600,000	120,000	na	405,205	81,041	na
OB-GYN	5	244,000	48,800	25,164	224,000	44,800	24,874
Urol	6	132,943	22,157	8,906	67,383	11,230	7,354
G. Sur	6	275,183	45,864	37,274	110,475	18,413	9,483
SrSp	10	1,090,930	109,093	129,223	536,100	53,610	48,957
Orth	11	809,085	73,553	35,129	360,121	32,738	29,015
Opht	7	101,500	14,500	13,472	57,500	8,214	10,015
Total	86	4,222,480	49,099	58,432	2,347,840	27,300	30,032

Specialty groups identical to those in Table 1. Na: not applicable due to averaging of members belonging to a single group. Amounts listed are those for survey respondents only.

are certainly conferring more indigent care than their share of the health care dollar would warrant. Critics of physicians who chastise us for being unsympathetic towards the poor and nonparticipatory in caring for them need to have their misconceptions corrected. Doctors, at least in Volusia County, are providing large amounts of uncompensated health care for the impoverished.

Caring for the indigent can be troublesome in ways other than pecuniary cost. Table 3 lists the major critiques of the present indigent care system in Florida as provided by the survey responders. The most common complaints were the lack of patient compliance in taking mediations, in keeping scheduled follow-up appointments, or in following instructions regarding their health needs. There is a general belief that more malpractice suits arise from attending to the indigents than for caring for paying patients. I cannot document the legitimacy of this opinion at the time of this writing.

A major source of complaint was the frustrations that physicians experience when caring for indigents. These frustrations were provoked by multiple stimulants: the inability of the patient to afford necessary laboratory or other diagnostic testing; difficulty in obtaining consultative help, or nursing home placement, or acceptance by tertiary or secondary care facilities of indigent patients. The lack of family and social backup for long-term care of patients was frequently cited. Finally, interpersonal frustrations with the patient — such as difficulty communicating with the patient, or perceived attitudinal problems, rudeness, lack of appreciation for the free care, and the demanding nature of some patients were commonly mentioned.

Many surgeons complained that a disproportionate share of indigent care was provided by physicians who provide care for traumatized patients. The data strongly confirm their complaints. Neurosurgeons, orthopedic surgeons and the anesthesiologists donated five to ten times more indigent care than did the general internist. Obstetricians also gave a very high amount of free care.

The respondent physicians had several suggestions for improving the indigent health care system (Table 4). The most common one was that special indigent care facilities — such as local clinics — be established to care for these patients. Physicians also thought that the reimbursement system for doctors should be improved; the data presented here support this contention. Many doctors recommended that medical liability for indigent care be limited in some fashion.

Suggestions about funding any new system were not overwhelmingly original. Many felt that an increase in some ill-defined tax should be implemented and most thought that the indigent care taxation should be assessed either at the state or local, rather than the national level.

Several other questions were posed by the survey (Table 5). The first asked whether some form of rationing of health care should be enforced. Most respondents said no; those that replied affirmatively usually qualified their answers by stating that

Table 3. — Problems With Present Indigent Care System in Florida That Were Cited by Respondents.

Problem with Current Indigent Care System Cited	No. Respondents Who Mentioned Problem
1. Patient ignorance; inadequate social support structure	14
2. Medicaid System inadequate	19
3. Transient or out-of-area patients	10
4. Increased malpractice liability attendant to care of indigents	24
5. Poor patient compliance; missed appointments; transportation difficulties	34
6. Patient inability to afford lab and diagnostic workups and medications	15
7. Inadequate reimbursement of physician costs for indigent care	10
8. Communication problems between M.D. and patient	4
9. Unavailability of subspecialist, nursing home, or tertiary care referral	12
10. Rudeness, attitudinal problems, lack of appreciation, and demanding nature of patients	18
11. Lack of facility devoted to indigent care	6
12. Disproportionate burden for indigent care placed on certain specialties	11

Table 4. — Recommendations for Altering and Financing Indigent Medical Care System Within the State of Florida.

General Recommendations for Indigent Medical Care System

Recommendation	Number Respondents
1. Establish a special facility for care of indigent	30
2. More adequate reimbursement for physicians	21
3. Limit or exclude malpractice liability	19
4. Require copayment from patient	7
5. Establish a mechanism for education of patients as to their health needs	6
6. Provide monies for transportation, medications, and supplies	5

Recommendations for Financing an Indigent Care System

Recommendations	Number Respondents
1. Non-specific tax by some government body	16
2. State taxation	12
3. Local, county tax	7
4. Special tax on alcohol, cigarettes	3
5. Capitation or a special insurance system	9
6. Tax credits for physicians who provide care	3
7. No response	38

elective care such as cosmetic surgery, organ transplantation, and dialysis should be limited.

One question asked was whether the physician would see indigent patients if malpractice liability was eliminated or limited. This was a poor question. Most respondents were already seeing indigents; only three said they would not see indigents despite medical liability reform.

A majority of doctors felt that HMOs should share the indigent health care burden. Obviously doctors and hospitals must shift some of the cost of their indigent care to their paying patients. If the HMOs remove a significant percentage of the paying patients from the pool available to non-HMO doctors and institutions without sharing in the indigent care burden then economic necessity will force non-HMO physicians and hospitals to stop caring for indigent patients.

Most doctors felt that emergency medical care for the indigent should be provided at the local hospital but that elective care should be provided either in a special clinic or in their own offices. Only ten doctors said they would not see indigent patients in their offices; of that ten, seven stated they were willing to care for them in a special clinic.

In summary, physicians continue to, as they have for centuries, provide a major share of the medical services given to the unfortunate who cannot pay for their medical care. One could fault this study from many angles: a survey method of data collection is certainly much less accurate than an audit of the financial records of a practice; we have not rigorously defined the indigent population in which we compare each patient's family income with an arbitrary level that is stated to divide the impoverished from the non-poor; we certainly could use larger numbers of respondents. Nevertheless this study is a good approximation of the activity of Volusia County physicians in the provision of health care to the needy. Even if our numbers are erroneous by a factor of 50%, the conclusions would remain the same. Doctors are

Table. 5 — Answers to Other Queries Pertinent to the Indigent Care Program.

Question	Answer (Number Responding) Yes	No	No Resp.
1. Should health care to indigent patients be rationed?	27	39	22
2. Would you treat indigent patients if malpractice liability was eliminated or limited?	72	3	13
3. Should HMOs be required to undertake some indigent health care?	56	11	21
4. Would you see indigent patients in your office if compensation was adequate?	63	10	15
5. If the answer to question No. 4 was "no" would you see indigents in a special clinic?	7	3	0
	Hospital	Clinic	MD Office
6. In what type facility should indigent patients receive emergency care?	52	6	3
7. In what type facility should indigent patients receive elective care?	19	31	16

providing more than their fair share of indigent medical assistance.

Does this sample from Volusia County reflect the degree of medical aid given by physicians throughout the state of Florida? Volusia County has a population of about 275,000 people, of which one quarter are medically indigent as defined by the University of Florida Study on Indigent Care. The physician composition encompasses all specialties and the proportionate numbers of physicians in each specialty is very similar to those in other parts of the state. Nevertheless, Volusia County does not have the special urban problems of Jacksonville, Miami, or Tampa and does not experience the influx of large numbers of migrant workers or illegal aliens that must be helped in other sections of the state. So one could argue that this study is not representative of the entire state. A statewide study is currently being conducted by the University of Florida under the leadership of Dr. Kerry Kilpatrick; it will be interesting to observe if our findings reasonably concur with those obtained from that project.

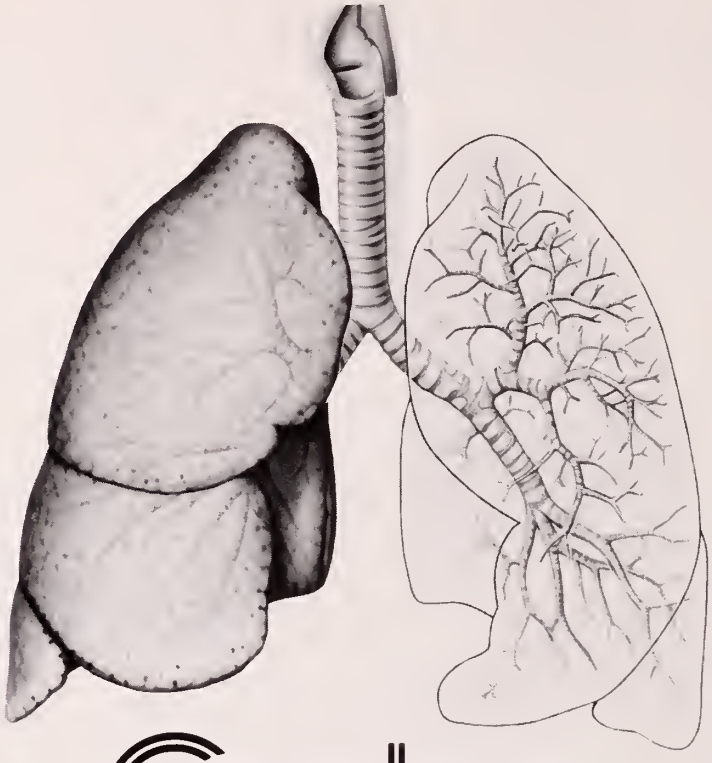
Non-medical people could scold those physicians who refuse to give medical help to the financially destitute or those doctors who complain about the interpersonal difficulties that they occasionally experience when interacting with some underprivileged patients. Unfortunately, the personalities of physicians are spun from the same skein of human filament as other mortals. However, the results of this study would suggest that physicans as a group are fulfilling their obligations to the poor in a noble and splendid fashion.

References

1. Duncan, R.P.; Colbert, J.L., and Pendergast, J.F.: State University Study of Indigent Care, Center for Health Policy Research, University of Florida Health Science Center, Gainesville, FL, 1986.
2. Reynolds, R.A. and Ohsfeldt (eds.): Socioeconomic Aspects of Medical Practice 1984, Chicago, IL, American Medical Association, 1984).

Jacques R. Caldwell, M.D.
Daytona Beach

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, H influenzae, Streptococcus pneumoniae, Streptococcus pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

© 1986, ELI LILLY AND COMPANY [060485LR]

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

600332

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

FLORIDA MEDICAL

DEPARTMENTS

☐ NOTES & NEWS, 1037
☐ DEAN'S MESSAGE, 1038
☐ ENCORES!, 1039

NOTES & NEWS

1987 Southeast Leadership Conference

All regional physicians are invited to attend the 1987 Southeast Leadership Conference, January 30-31, at the Waverly Hotel, Atlanta. The Conference, sponsored by the Medical Association of Georgia, will feature tort reform and malpractice litigation, the demand for high quality of care, and pressures in the medical marketplace in the 1½ day program.

Fee for state medical association members in the southeast is $75, and $175 for non-member physicians. Please mail to Leadership Conference, Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, 30309. For further information, call Stephen Davis, Director of Education, MAG, at (404) 876-7535.

The Waverly Hotel, the site of the Conference, in located in northwest Atlanta, I-285 at I-75. MAG's special room rate is $79 single/double. Room accomodations may be made by calling the hotel at (404) 953-4500.

Program Schedule

Friday Afternoon, January 10

1:00 Welcome & Introduction
John D. Watson Jr., M.D., President
Medical Association of Georgia

1:00 1987 Leadership Conference Keynote Speaker
"Organized Medicine's Challenges Today"
James H. Sammons, M.D.
Executive Vice President
American Medical Association

Three Perspectives: The Continuing Challenge of High-Quality Care

1:45 What Are The Practitoner's Responsibilities for Quality of Care?
Arnold S. Relman, M.D., Editor
The New England Journal of Medicine

2:05 New Joint Commission Initiatives in Assuring Quality of Care
Dennis S. O'Leary, M.D., President
Joint Commission on the Accreditation of Hospitals

2:30 Does Litigation Affect Quality of Care?
Sidney M. Wolfe, M.D., Director
Public Citizen's Health Research Group
Washington

3:15-5:00 Questions and Discussion

6:00-7:30 Leadership Conference Reception

Saturday, January 31
Morning Session
Tort Reform and Malpractice Litigation

9:00 Introduction of Guest Speaker
James A. Kaufmann, M.D., Chairman
MAG Council on Legislative Affairs

9:10 Georgia's Prospects for Tort Reform
The Honorable Zell Miller
Lieutenant Governor
State of Georgia

10:00 Tort Reform: The National Perspective
Ross N. Rubin, J.D., Director
AMA Division of Federal Legislation

11:00 The Physician, the Family and the Stress of Being Sued
Sara C. Charles, M.D.
Chicago

11:30-1:00 Lunch on your own

Afternoon Session
Pressures in the Medical Marketplace

1:00 Introduction — Dr. Watson

1:05 Government's Expanding Role in Monitoring Quality of Care
Richard P. Kusserow, Inspector General
U.S. Department of Health and Human Services

Debate: Do Solo and Small Group Practices Have a Chance?

1:45 Paul M. Ellwood Jr., M.D.
President, Paul Ellwood & Associates
Excelsior, Minnesota

2:10 Brant Mittler, M.D.
Vice President, Physicians Who Care
San Antonio

2:35 Questions and Discussion from the Audience

4:00 Adjourn

8:00 Optional Evening Entertainment — The Atlanta Symphony Orchestra

Clinicians prescribe multiphasics for new patients more often than any other oral contraceptive

Fifty-seven percent of health-care professionals vote the low-dose multiphasic oral contraceptive (OC) the pill of choice for new patients — choosing Ortho-Novum 7/7/7 nine times more often than any other multiphasic — according to a recent survey in *Contraceptive Technology Update (CTU).*

Ortho-Novum 7/7/7 is a low-dose OC whose progestin (hormone) gradually increases throughout the menstrual cycle. Phasic pills offer women comparable

protection but fewer nuisance side effects associated with older, higher-dose formulations.

Clinicians are choosing multiphasics, according to *CTU's* 1986 Oral Contraceptive Survey, because they want patients to take an OC with the lowest hormone-containing formula possible that is still highly effective. "If a fly swatter will do the job, why use a baseball bat?" said Shirley Peters, a registered nurse and nurse practitioner of the Sonoma County (California) Public Health Department.

Clinicians surveyed indicate that they prefer Ortho-Novum 7/7/7 over other phasic brands partly because of their desire to prescribe a phasic pill containing norethindrone, a low-dose progestin that inhibits ovulation.

David A. Grimes, M.D., Professor of Obstetrics/Gynecology at the University of Southern California School of Medicine, said that survey results reflect a national trend toward lower-dose OCs that "should certainly be encouraged." Leon Speroff, M.D., Professor and Chairman of Reproductive Biology at Case Western Reserve University School of Medicine in Cleveland, agreed, adding, "If triphasics will take us in that direction, then that's terrific."

The survey also revealed the need for better patient education concerning OCs. Misconceptions about the pill still abound, despite many new studies that demonstrate its safety. In fact, many women are not aware of the OCs' *non*-contraceptive benefits, including the ability to alleviate dysmenorrhea, irregular menstrual cycles, and dysfunctional uterine bleeding. The pill also offers women protection from ovarian and uterine cancer. Fifteen percent of pill users may experience some minor problems, but most of these difficulties clear up within two or three months.

The first annual *CTU* Survey on Oral Contraceptives included clinicians in 48 states. It polled 609 doctors, nurse practitioners, physician assistants, and other health professionals who subscribe to *CTU* or attended recent family planning or medical conferences.

CTU is published by American Health Consultants, Inc., in Atlanta, Georgia.

DEAN'S MESSAGE

Current dilemmas facing medical students

Many complex dilemmas are facing medical students at this time. Included are their massive responsibility to repaying the financial aid assistance, the availability of specialty training and the uncertainties of future practice options. The financial burden on today's medical students poses an enormous problem, one much greater than faced by past generations. Eighty-five percent of respondents to the Association of American Medical Colleges survey of 1985 had educational debt upon graduation from medical school. Mean indebtedness increased 13% from 1984 to a reported figure of $26,496[1] in 1985. While only 29.5% of medical school seniors incurred a debt as college undergraduates, 84.4% reported debts after graduation from medical school.[2] Our most recent figures for the University of Miami show that 77% of graduating seniors have received some type of financial aid; mean indebtedness for the student is approximately $42,000.

The question of what impact this will have remains unanswered. However, from peer feedback, the following conclusions can be drawn. Despite a strong desire on the part of many students to consider lower paying but stimulating careers in academia, it has become increasingly difficult for them to do so. More importantly, while society requires more primary care physicians, financial restraints encourage today's students to enter the more economically rewarding specialized disciplines. While tuition continues to inflate in both the private and public sector, governmental support of medical students continues to decline.[3] Hafferty and Boulger have reported that increasing indebtedness has led to a tendency for students to change their choice of specialty, potential site of practice location, and type of practice arrangement.

Unfortunately, while society is calling for a redistribution of graduating physicians to rural areas, economic considerations are once again working in opposition, necessitating that physicians work in oversupplied urban areas.

Future practice options are yet another issue confronting today's medical students. Everyone recognizes that health care delivery is undergoing a revolution. Health Maintenance Organizations, PPOs, the introduction of DRGs into our national health care policies, and the specter of for-profit business in medicine are rapidly changing the face of health care in the United States. As students and soon to be postgraduate trainees are confronted daily by the uncertainty of what lies ahead of us, we are becoming more concerned about how these critical issues will impact on the quality of patient care. Add to this what we perceive as an increasingly hostile climate created by the professional liability "crisis," medical students are questioning more and more the future of medical practice and their role in it.

Fortunately, we are realistic enough to appreciate that most things are cyclic and that there is probably a constant; that most people desire quality health care. We feel comfortable that despite the unprecedented challenges, today's students' strong commitment to the profession and to individuals in need will

maintain the quality. Based on our faith in our fellow students and our educational experience, we feel "the glass is still more than half full."

References

1. Residency and Career Plans and Indebtedness of 1985 Medical School Graduates, Journal of Medical Education, Vol. 61, No. 5, 424-427.
2. Thomae-Forgues, M.; Dial, T.H., and Boerner, R.J. Curriculum Evaluation, Education Financing, and Career Plans of 1983 Medical School Graduates, Journal of Medical Education, Vol. 59, September 1984, 691-698.
3. Hafferty, F.W., and Boulger, J.G.: A Look by Medical Students at Medical Practice in the Future, Journal of Medical Education, Vol. 61, No. 5, 359-367.

Eric Lieberman
Student Council President
Class of 1987
University of Miami
School of Medicine

Steve Falcone
Student Council Vice President
Class of 1987
University of Miami
School of Medicine

ENCORES!

Caveat, Doctor

Do you know that your hospital case, rejected by the Peer Review Organization for reimbursement, will also automatically knock out your fee collection from Medicare? This is an advance notice promised by the Health Care Financing Administration.

Shocking? Well, hardly when you examine these examples of other PRO activities.

(1) All readmissions within a 15 day interval will be scrutinized and if your efforts on the first admission are deemed insufficient for protecting against a second admission, the second hospitalization will certainly be denied.

(2) All admissions for one or two days will be reviewed. We wonder in the case of the expiration within 48 hours, whether the PRO considers this hospitalization unjustified for such an uncooperative patient or physician for that matter.

(3) Do you know that your anemic patient might not be covered unless his hemoglobin is less than seven and hematocrit 21?

(4) Would you suspect that your acutely ill 90-year-old patient might not be covered if his temperature is less than 103, 102 with a white count above 15,000?

(5) Do you know that congestive heart failure is not a good enough diagnosis for admission unless "fatigue, palpitation, dyspnea or anginal pain" with "less than ordinary physical activity" was also present? The potential for pulmonary edema and exitus is not recognized by PRO as a reason for hospitalization.

(6) Do you know that your 85-year-old patient with severe vomiting and diarrhea will not be approved for hospitalization unless she also has continuous hemorrhage, wound disruption, ileus, or a serum sodium over 150 mg., hematocrit above 55, urine specific gravity over 1.026, BUN over 35 and creatinine over 2? If you mention two inch pleats in the skin as poor skin turgor, that might help.

Now, although you have admitted your sick patient according to guidelines, your troubles are just beginning. Something called "intensity of therapy" is now open for review. For example, if your penicillin allergic patient has a pneumonia with an organism responsive to erythromycin, he will not pass muster with oral therapy, only intravenous therapy. Also a little oxygen and IPPB may help her since her apartment is not generally equipped with such necessities.

If your patient was hit by a car and had a compression fracture of the spine, be sure that his pain is treated with intramuscular injections, not oral medications. And, you might use traction even if your orthopedist does not think it might help. Otherwise, the PRO says that your patient could just as well walk home and lie down with 50 Tylenol codeine tablets until his fracture heals.

One more thing, our surgeons are now well oriented to ambulatory care arrangements for such minor operations as cataract removal, pacemaker battery maker replacement, breast biopsies, etc. But, consider your patient who fell down the steps on his head, entitling him to a fast ride to the hospital by Fire Rescue.

After two days of tests and observation, you finally figured out that his problem was really due to asystolic intervals of 3-4 seconds, and he really needs a pacemaker before he tries another flight of stairs. You need to call the PRO "48 hours before the implant" at 1-800-282-7876 Monday-Friday, 8:30 a.m.-5:00 p.m. Your watch says Friday 5:05 p.m., so you will call on Monday and if the line is not busy, you are O.K. Or you could put in a temporary pacemaker, or even consider it an emergency procedure, insert it promptly and then go ahead and explain it on Monday!

Here's one more review to think about. Your patient entered under appropriate guidelines, you intensively used the hospital facilities, your utilization review committee applauded your wisdom in curing the patient in record time, and you are now writing discharge orders, prescriptions, ordering home health care, and the like. Do not forget to write a note about maximal hospital benefit because now the PRO

will be doing random discharge reviews by a whole bunch of weird provisos.

For example, serum K must be normal for the last two days, there shall be no change in type or dosage of antiarrhythmic drugs and no evidence of new heart damage or EKG changes in the last two days, and thou shalt not give parenteral narcotics for the last 24 hours.

All of this is reviewable by the PRO to be sure the patient is stable and will not dare to return within 15 days. Also the PRO will review all deaths, nosocomial infections and trauma suffered in the hospital.

Well, I could go on further but you might like to explore the PRO manual in your hospital yourself. You cannot tell the players without a program. And do not forget to look at page 52 under *Sanctions*. This means you and me.

Rose E. London, M.D.
Miami Beach

Reprinted with permission from *Miami Medicine*, the official publication of Dade County Medical Association, November 1986, pg. 11.

H M Oh No!

Dear Mom and Dad,

Just thought I would drop you a line to let you know how us city-folks are doing. Living out there on the farm, you can soon lose touch with what the civilized world is up to.

Take health care for instance. I am sure you recall all the times we had to drive the five miles to Attapulgus to see our doctor, or he had to drive the five miles to see us. Sometimes we waited for hours to see him because he was the only doctor around. But getting prescriptions filled was a snap because he usually stocked everything from bandaids to back-braces. I too-well remember how much penicillin he stocked because his nurse (the one that was a welder in the airplane factory) almost always wrestled me down to shoot me in the fanny before I could escape. I can still smell the unique aroma of his waiting room too; a blend of heavy alcohol vapors and the pungent fumes of chicken poop and pork rind. I was nearly out of high school before I realized that he would accept money as payment. Boy, those were strange times.

Nowadays we lucky dogs here in the big city are bathing in the golden light of *medical consumerism*. In case you do not know what that means, let me elaborate a little. Not only do we have more than one doctor to choose from (actually about 200), but we must have half a dozen Health Plans to choose from as well. And on top of that we are surrounded by three hospitals, an out-patient surgicenter, a birth house, and at last count, five walk-in clinics (they call them "Docs in a box"). Now that sounds great but the best news is that all of them are knocking themselves out just to be able to serve people like little old me. The hospitals are in a gas war, the doctors are giving 20% discounts (remember they all used to drive Cadillacs), and even the Health Plans themselves are willing to gamble millions of dollars just to get the business.

Now let me back up for a minute. I know you are wondering what in the world a Health Plan is. Well it is sort of like what insurance used to be but it is much, much cheaper. For instance, I figure I will save enough money on my Plan (I'll tell you more about it later) over the next five years to buy that Winnebago and hit the road to Rio. Like I said, all of these Plans are just dying to serve us. They are advertising on the radio, in newspapers, and on T.V. like what we used to call a fire sale. It is really hard to tell them apart though. They all have catchy names, promise the same services, and have about the same panel of doctors. I think the most important thing I had to consider is what I call the BOTTOM LINE . . . the big BUCK! Yeah, I really have Rio on the brain.

So I signed up with the one that offered the most incredibly low rates — can you believe just $12 a month! Yep. I am a proud member of HMOh No! I got to choose my primary care doctor from a list of 23 doctors; no joke, 23. Dr. Rusty is my man (I picked him because his was the only name I could pronounce). I had to leave Dr. Hearty after being with him for 27 years. He was not on my Plan's panel, and I am not about to pay an extra $20 out of my pocket just to see him once a year even if he did save my life with a brain bypass. Rio is on that same brain remember.

I already had an occasion last week to really put the Plan to the test. I was scuba diving in a sinkhole down south of town checking out my new dry suit. The automatic venting valve jammed and when I overinflated the suit I was propelled to the surface with such velocity that I impaled myself on a tree limb some eight or ten feet above the water's edge. My buddy naturally became alarmed and alerted the only hospital that offered Sea/Air Rescue services. In no time I was whisked away via helicopter to the emergency room. There I encountered a small problem. The surgeons were standing by to stop the blood spurting from my belly, the recompression chamber was prepared to treat my air embolism, but no one could act without Dr. Rusty's approval. Turned out that he only practices in one hospital (I think they give him free parking and designer scrubs or something), and this was not it. In my last conscious effort I fished out my American Express card and fired off a short prayer. It must have worked because I awakened the next day in stable condition. Two days later my alloted hospitalization time was up and I was discharged in a wheelchair. The Plan provided a home healthcare nurse for thirty minutes each day for a week until I could get the catheter and chest tubes

out and wean myself from the respirator. I know this novel approach saved a lot of money but my trip to Rio was set back a year by what I had to pay for the recompression chamber (HMOh No does not cover recompression).

Mom, you are probably worrying about all the pain I was in, but try to relax. My Plan provides medication for peanuts. My doctor wrote prescriptions for all the pain medication I needed. The panel of drug stores unfortunately did not include the one next door to my townhouse, but I did not mind driving across town for a little relief. The traffic really was not bad at that time of night (they are only open after midnight).

Thanks to HMOh No I am back at work again. I like my new job at the theater. Running the movie projector does not require much effort, and I was getting a little burned out as a professional athlete anyway. Dr. Rusty is some kind of guy. Every time I want to go see a specialist about some picky problem like this fluid that continually runs from my ear, or the inability to control my bowels, he comes through with a new and amazing treatment. I figure he is either a genius or there is something else here that HMOh No is not telling me.

Well, you can see how far we have come since the old days. If you ever decide to move into town, I will help get you into the Plan. I understand a new competitor is coming in soon to build a new Wellness World — a one-stop shopping mall for all your health care needs: doctor's offices, pharmacies, walk-in clinics, stress management and weight-loss centers, and out-patient surgery all under one roof. Sounds too good to be true!

On second thought, you guys are probably too old-fashioned for this idea. You would probably still prefer to be able to choose any doctor or hospital you wished, even if it cost a little more. And I expect you still believe in that sacred doctor-patient relationship stuff where the doctor always has your best interest in mind and you trust whatever he tells you. Maybe you had better just stay put for now and if I ever hear of a Plan that offers such features I will give you a call.

Come to think of it, if you could ever get enough doctors to agree on and support such an idea, there are probably enough old-fogeys like you around to make it fly . . . but we know that is not likely, and I am not the only one with Rio on the brain.

Love,
C.T.

Chickweed Taylor, M.D.
Tallahassee

Reprinted with permission from *CapScan*,The Newsletter of Capital Medical Society, No. 150, Nov. 1986, pgs. 7-8.

ALAN GRIECO, Ph.D.
CLINICAL PSYCHOLOGIST
Announces the opening of his practice in Winter Park

A general practice with specialization in evaluation and treatment of Sexual Dysfunction. Dr. Grieco completed a Postdoctoral Clinical Fellowship at the Masters and Johnson Institute and has served as Clinical Assistant Professor, School of Medicine, University of Missouri-Columbia.

Medical and nursing support staff are in-house, full time to assist in medical evaluation of the physical aspects to sexual dysfunction. A female nurse counselor is also available.

Out-of-town referrals may choose a two-week intensive therapy course. Individual, group, and family therapy is also available. Dr. Grieco also maintains a general practice.

Across from the Winter Park Memorial Hospital. Evening and weekend appointments available.

Call for free brochure: (305) 740-7777
111 Lakemont Avenue, Suite D
Winter Park, Florida

Hepatobiliary Diseases in Clinical Practice VII
February 19-21, 1987, Sheraton Bal Harbour, Florida
Sponsored by: University of Miami School of Medicine, Division of Hepatology
Course Directors: Eugene R. Schiff, M.D., F.A.C.P.
Leon Schiff, M.D., Ph.D., M.A.C.P.

Guest Faculty

W. Scott Brooks Jr., M.D.
Emory Univ. School of Med.
Atlanta, GA

JeanPierre Delmont, M.D.
Universite de Nice
Nice, France

Jules L. Dienstag, M.D.
Harvard Medical School
Boston, MA

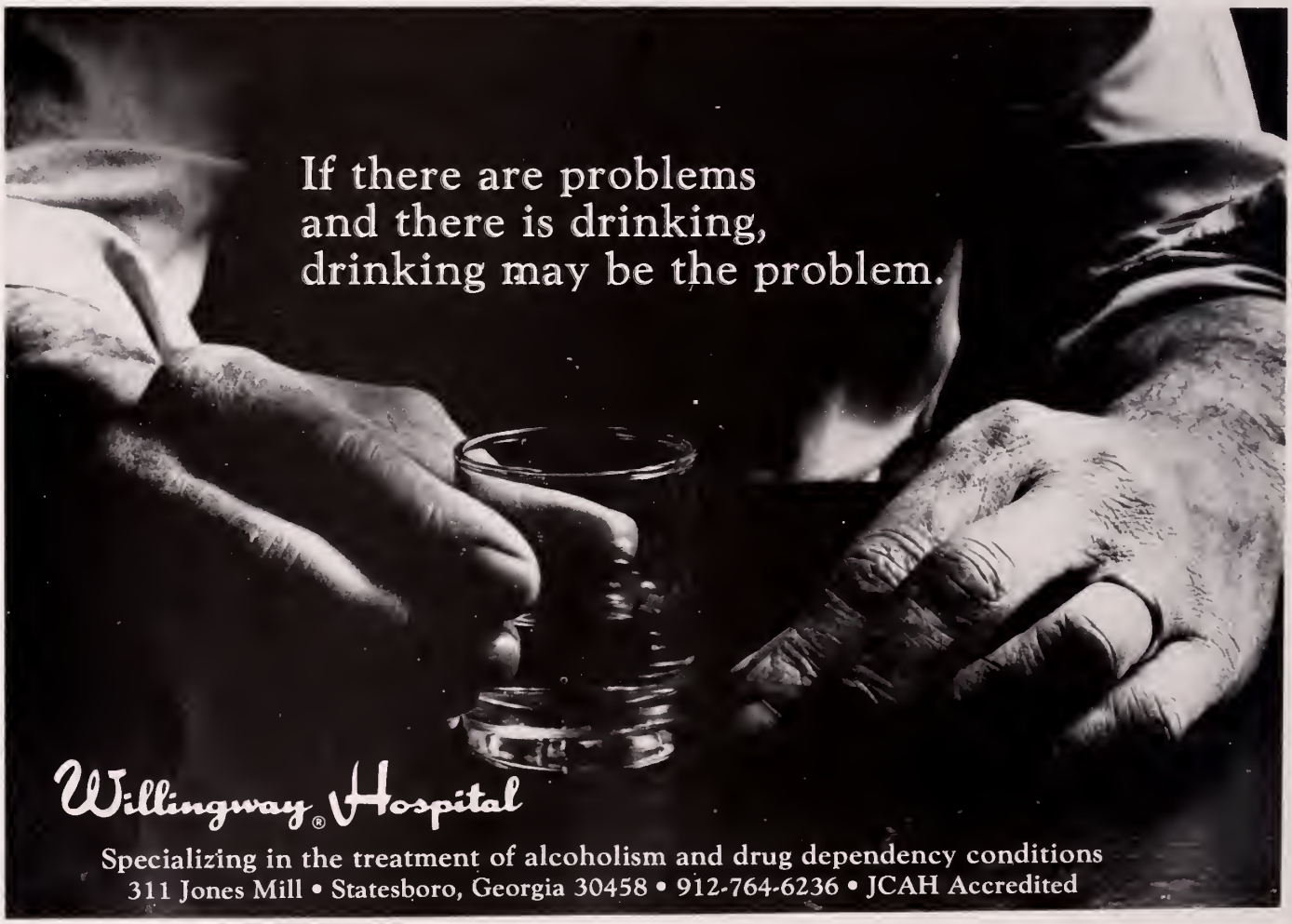
Marshall M. Kaplan, M.D.
Tufts Univ. School of Med.
Boston, MA

Jay H. Lefkowitch, M.D.
Columbia Univ. College of Physicians and Surgeons
New York, NY

Frank G. Moody, M.D.
Hermann Hospital
Houston, TX

David H. Van Thiel, M.D.
University of Pittsburgh School of Medicine
Pittsburgh, PA

The course is directed toward internists, gastroenterologists, alimentary tract surgeons, hepatologists and other physicians, residents, nurses and allied health professionals who deal with these complex patients and issues. Didactic presentations will be augmented with extensive audiovisuals, panel discussions, workshops, and question/answer sessions.
Course Hours: 12.0 Category I AMA
Course Fees: $325 Physicians in practice; $395 after January 1, 1987; $200 Residents/Allied Health Professionals
For Further Information: Division of CME D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami, FL 33101, (305) 547-6716





CARDIZEM® FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

diltiazem HCl/Marion

60 mg tid or qid

Brief Summary
Professional Use Information

CARDIZEM*
(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159.* ***3.*** *Johnstan DL, Lesaway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris. A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap. 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

Another potent benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137

0246M6

Give your angina patients what they're missing...



CARDIZEM®: FEW SIDE EFFECTS

diltiazem HCl/Marion

- ***Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate***
- ***Proven efficacy when used alone in angina[1]***
- ***Compatible with other antianginals[2,3]****
- ***A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD[4,5]***

***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.

Specify "Dispense as written" for the original hydrocodone analgesic.

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. S68S

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.



Knoll Pharmaceuticals
A Unit of BASF K&F Corporation
Whippany, New Jersey 07981

knoll®

BASF Group

© 1986, BASF K&F Corporation 5768/9-86 Printed in U.S.A.

vicodin® C III

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.



Freedom from pain

Just one part of pain relief therapy.

Vicodin® provides greater patient acceptance

COMPARATIVE PHARMACOLOGY OF THREE ANALGESICS

	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- Vicodin offers: less nausea, less sedation, less constipation.

...and longer lasting pain relief– up to 6 hours.

- Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.[1]
- In a double-blind study, Vicodin (2 tablets), provided longer lasting pain relief than 60 mg. of codeine.[2]

Plus...

- Vicodin offers the convenience of CIII prescribing.
- Dosage flexibility–1 tablet every 6 hours or 2 tablets every 6 hours (up to 8 tablets in 24 hours).

vicodin®

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

The original hydrocodone analgesic.

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Bradford County Auxilians provide comfort for nursing home residents

Florida's elderly population is growing at a fast pace. We have more citizens over the age of 60 than any other state. There are many challenges in our communities calling us to understand and respond to the unique needs of the aged. The Florida Medical Association Auxiliary is helping to meet these needs through numerous volunteer hours dedicated to serving senior citizens in a variety of useful projects. The love and commitment of dedicated Auxilians can be seen in hundreds of programs in communities all over our state.

Auxilians in Bradford County have found a way to show that they do care for the older adults in their area. They have adopted a project which helps to improve the quality of life for elderly residents of a local nursing home. They have recognized the fact that emotional support, nurturance, and intimacy are critical elements for those away from home, and dependent upon others for their care.

The uniformity of institutional settings often leaves a void that is difficult to understand. A certain element of depersonalization occurs causing the individual to search for something to call his or her own; something secure! Bradford County Auxilians discovered that a personalized comfort pillow gave residents at the Whispering Pines Care Center a joyful feeling of individuality. Residents became attached to "their pillows." For the ladies, they designed a very special lap robe (long apron) that could be used to cover their legs when sitting in a chair.

The comfort pillows are of different shapes and sizes. Colorful wash and wear fabrics are made into pillows by the Auxilians and filled with a washable pillow stuffing. These are welcomed by both men and women for that little space under a tired ankle, a sore elbow, or just to nestle in the wheelchair as "something of their own."

The lap robes (or long aprons) are made of bright, colorful wash and wear fabrics. The women wear these while sitting in their wheelchairs. The robes completely cover their legs, and the ladies "feel very feminine" in their own pretty lap robes. They beam with joy and say that they feel "dressed up."

Bradford Auxilians meet every week for two hours where they cut, sew, trim, press, and visit with each other in friendly fellowship. They donate their time and the materials for the comfort pillows and lap robes. Their reward comes when they see the expressions of satisfaction and happiness on the faces of the residents of the nursing home.

Engineering this project is the Bradford County Auxilian President, Anna Felos. Marty Barry provides the facility of her needlepoint shop for the members to congregate and fashion the pillows and robes. What started out as a Doctors' Day project in honor of their doctors, has now become a most worthwhile program of the Bradford County Auxiliary enriching the quality of life for nursing home residents of their area.

For complete instructions on how to make the lap robes and comfort pillows, contact the Bradford County Auxiliary President, Anna Felos, P.O. Box 843, Starke, Florida 32091.

Everyone needs sombody sometime. Our senior citizens need us now. They need our commitment and our love. "The great tragedy of life is not that men perish, but that they cease to love" (Somerset Maugham). Working with senior citizens can bring love into your life; and a new meaning and purpose. The rewards are multiplied. By helping others, you help yourself. Our work may help lead our state to a more enlightened approach to the treatment of our older population, and a greater appreciation for this vital resource.

Mrs. Walter (Isabella) Laude, Ph.D.
Auxiliary Liaison Editor
Babson Park

An Invitation from the Florida Medical Association

FLORIDA MEDICAL ASSOCIATION, INC.

Membership Benefit Program
FMA MAGAZINE PROGRAM
29 Glen Cove Ave.
Glen Cove, NY 11542
(516) 676-4300

Dear Colleague:

FLORIDA MEDICAL ASSOCIATION members may now purchase magazine subscriptions at the lowest prices available!

The **FMA MAGAZINE PROGRAM**, recently approved by your Association, offers hundreds of popular magazines to you. FMA members qualify for low professional subscription rates for magazines for office/reception room use. In addition, many members are involved in continuing educational programs in colleges and medical institutions and may order magazines at special educator rates. Thus we have arranged with Subscription Services, Inc. for this program. If you wish to qualify for educator orders, be sure to complete the section of the coupon that requests your affiliated institution. Please note that the list contains prices in both categories.

Renewals, extensions, and new subscriptions may be obtained at the low rates indicated on the enclosed list and order form. For renewals, include the address label from the magazine and identify it with the name of the publication. Compare the prices with what you are currently paying!

THE PERSONAL INVENTORY PLAN
If you are already subscribing to other magazines, you may benefit by using the **FMA MAGAZINE PROGRAM PERSONAL INVENTORY PLAN.** Simply clip all of your magazine address labels, write the name of the magazine on each label, and include them with your order. Then all of the magazines you are now receiving will be logged by the **FMA MAGAZINE PROGRAM.** No orders will be placed without your approval. Renewal information will be submitted to you for review in advance of expiration dates.

In the event that you discover a lower advertised price for a magazine offered through our Program, let the Plan administrator know. Every effort will be made to obtain the publication at that price. Also, if there are magazines desired which are not listed, the Plan will do its best to make them available to you.

You may call the magazine service number (516) 676-4300 for additional information.

This program, represents another benefit of membership in your Association.

Thank you.

Henry M. Yonge, M.D.
Secretary
Florida Medical Association

MAGAZINE SUBSCRIPTIONS AT HUGE SAVINGS

FLORIDA MEDICAL ASSOCIATION MAGAZINE PROGRAM

a division of Subscription Services, Inc.

29 Glen Cove Avenue • Glen Cove, New York 11542 • 516-676-4300

Our members qualify for low professional subscription rates for magazines for office reception room use. In addition, many members are educators associated with universities or teaching hospitals and may order magazines at special educator rates. If you wish to select any educator rates, be sure to complete the section of the coupon that requests your affiliated institution. Please note that our list contains the prices in both categories. You may renew or extend your present subscription through the program.

PUBLICATION	(No. of issues per yr.)	REG. SUBSCR. PRICE	YOUR OFFICE PRICE	YOUR EDUC. PRICE
American Health	10	14.95	12.95	11.95
American Heritage	6	24.00	18.00	18.00
Amer.Photog.[Special:9 iss.]			7.47	7.47
Americana	6	11.95	11.95	9.95
ArtNews	12	29.95	25.95	25.95
Atlantic Monthly	12	9.95	9.95	9.95
Audio	12	17.94	8.97	8.97
AUTOMOBILE	12	24.00	12.00	
	2 yrs		22.00	
Baseball Digest	12	14.95	14.95	
for Educators: 10 issues				7.97
Basketball Digest	8	9.95	9.95	7.97
#Better Homes&Gdns	12	14.00	7.00	14.00
#BICYCLING	10	15.97	8.00	12.97
Black Enterprise	12	15.00	15.00	11.95
Boating	12	19.98	16.97	16.97
Bon Appetit	12	15.00	15.00	15.00
Boys Life	12	13.20	13.20	13.20
Car & Driver	12	16.98	11.99	11.99
Changing Times	12	15.00	9.97	9.97
#Connoisseur	12	19.95	10.00	19.95
Consumers Reports	12	16.00	16.00	16.00
#Cosmopolitan	12	24.97	15.00	24.97
Cruising World	12	18.00	18.00	14.00
Cycle	12	13.98	6.99	6.99
Cycle World	12	13.94	7.97	7.97
DISCOVER	12	23.95	13.00	14.95
Downbeat	12	18.00	18.00	9.95
EBONY	12	16.00	9.97	9.97
The Economist	52	85.00	51.00	51.00
#ELLE	12	24.00	16.00	
EM (Ebony Man)	12	24.00	19.95	19.95
ESQUIRE	12	17.94	9.95	9.95
Essence	12	12.00	9.96	9.00
Family Circle	17	14.97	9.97	
Family Computing	12	19.97	11.97	11.97
Family Handyman	10	9.95	9.95	5.95
Field & Stream	12	15.94	8.97	8.97
Fifty Plus	12	15.00	11.97	11.97
Financial World	26	41.95	24.94	
FLORIDA TREND	13	24.00	24.00	
Flying	12	18.98	15.97	15.97
Food and Wine	12	18.00	9.00	15.00
Football Digest	10	12.95	12.95	7.97
Forbes	28	42.00	42.00	28.00
Fortune	26	44.00	35.30	22.25
Games Magazine	12	15.97	15.97	15.97
Gentlemens Quartly	12	18.00	13.50	
Glamour	12	15.00	12.00	
Golf Digest	12	19.94	11.98	11.98
Golf Illus.[Special:8 issues]			5.97	5.97
Golf Magazine	12	15.94	9.97	9.97
#Good Housekeeping	12	15.97	9.97	15.97
Gourmet	12	18.00	13.50	15.00
#Harpers Bazaar	12	16.97	8.97	16.97
Harpers Magazine	12	18.00	9.97	9.97
Health [Special:9 issues]			9.97	9.97
High Fidelity	12	13.95	6.98	6.98
Home Mechanix	12	11.94	8.97	8.97
The Homeowner[Special:6 iss]			8.97	8.97
Home Viewer	12	18.00	11.97	11.97
Hot Rod	12	13.94	8.97	8.97
House and Garden	12	24.00	18.00	
#House Beautiful	12	15.97	7.99	15.97
Humpty Dumpty (4-7)	8	11.95	9.97	9.97
Inc.	12	24.00	12.00	12.00
Jerusalem Post	24	18.46	18.46	15.97
Jet	52	36.00	26.00	26.00
Ladies Home Journl	12	20.00	13.32	10.00
LIFE	12	32.50	16.25	
M (Civilized Man)	12	24.00	19.95	
Mademoiselle	12	15.00	12.00	
McCall's	12	11.95	7.95	
Metropolitan Home	12	18.00	18.00	9.00
Modern Photography	12	13.98	7.98	6.99
MONEY	12	29.95	15.00	
Mother Jones	12	24.00	16.00	16.00
Motor Trend	12	13.94	7.97	7.97
MS Magazine	12	16.00	10.97	10.97
The Nation	52	28.00	28.00	
for Educators: 24 issues				9.95
Nation's Business	12	22.00	12.97	12.97
Natural History	12	20.00	20.00	
N.E.Journal of Med.	52		60.00	
New Republic	52	48.00	48.00	28.00
N.Y. Rev of Books	17	28.00	28.00	25.95
New Woman	12	15.00	9.95	11.97
New Yorker	52	32.00	32.00	20.00
NEW SHELTER,new name:PRACTICAL HOMEOWNER				
#NEWSWEEK	52	41.00	20.80	21.85
Omni	12	24.00	15.96	15.96
1001 Home Ideas[Spec'l:8 iss]			11.97	11.97
Organic Gardening	12	12.97	9.97	9.97
Outdoor Life	12	13.94	7.97	7.97
Outside	10	16.00	12.00	8.97
Ovation	12	18.00	10.00	10.00
PARENTS	12	18.00	9.00	
Penthouse	12	36.00	30.00	30.00
People	52	56.00	56.00	28.25
Personal Computing	12	18.00	18.00	11.97
Petersens Photgrph	12	13.94	6.97	6.97
Playboy	12	25.00	21.50	21.50
#Popular Mechanics	12	13.97	7.00	13.97
Popular Photogrphy	12	11.97	5.99	5.99
Popular Science	12	13.94	7.97	7.97
#PRACT'L HOMEOWNER	9	10.97	5.50	9.97
#PREVENTION	12	13.97	7.00	13.97
PSYCHOLOGY TODAY	12	15.99	8.00	12.97
Reader's Digest	12	15.41	15.41	15.41
#Redbook	12	11.97	6.97	11.97
Road and Track	12	17.94	12.99	12.99
Robb Report	12	65.00	65.00	
The Runner [Special:8 iss.]			8.97	8.97
#RUNNER'S WORLD	12	19.95	10.00	12.97
Sail	12	21.75	21.75	21.75
Saturday Eve. Post	9	12.97	12.97	12.97
Savvy [Special:9 issues]			8.97	8.97
#Science Digest	12	13.97	6.99	13.97
Scientific Amer'n	12	24.00	24.00	24.00
Self	12	15.00	12.00	
Seventeen	12	13.95	13.95	13.95
Ski	8	11.94	6.97	6.97
Skiing	7	9.98	5.97	5.97
Skin Diver	12	13.94	7.97	7.97
SOUTHERN ACCENTS	12	18.00	16.00	
SPORT	12	12.00	7.97	7.97
Sporting News 24:6 mo		22.50	11.97	11.97
#Sports Afield	12	13.97	6.99	13.97
SPORTS ILLUSTRATED	54	58.80	34.00	29.45
Stereo Review	12	9.98	4.99	4.99
S.Porters Pers.Fin.	12	19.97	19.97	
Teen	12	12.95	7.95	7.95
Tennis	12	17.94	8.97	8.97
TIME	52	58.25	29.25	
#Town & Country	12	24.00	12.00	24.00
Travel & Leisure	12	25.00	12.50	25.00
TV Guide	52	31.20	31.20	26.00
UNIQUE HOMES	6	30.00	24.97	24.97
USA Today	260	92.00	92.00	78.00
U.S.News&World Rep	52	34.50	34.50	17.25
US Magazine	26	23.95	12.95	12.95
	2 yrs.	23.95	23.95	
Vegetarian Times	12	19.95	14.95	14.95
Video	13	12.00	8.97	8.97
Video Review	12	12.00	6.97	6.97
Village Voice	52	32.76	32.76	16.50
Vogue	12	24.00	21.00	
W Magazine	26	26.00	23.00	17.95
Weight Watchers	12	13.97	11.97	11.97
Woman's Day	17	15.13	15.13	15.13
Women's Sports	12	12.95	7.97	8.95
WORKING MOTHER	12	11.95	7.95	
Working Woman	12	18.00	12.00	15.00
World Press Review	12	16.95	16.95	14.98
World Tennis[Special:6 issues]			5.97	5.97
WORLD TRAVELING	4	11.00	9.95	9.95
Writer's Digest [Spec:9 iss.]			9.97	9.97
Yachting	12	19.98	16.97	16.97
Yankee (Colonial)	12	18.00	18.00	14.95
YM (Young Miss)	12	14.00	10.95	10.95
# BUSINESS CARD NEEDED FOR OFFICE PRICE				

FMA MAGAZINE PROGRAM
29 Glen Cove Avenue
Glen Cove, New York 11542

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Complete for Educator rates:

_____ Name of Educator

_____ Affiliated Hospital/School

☐ VISA
☐ M/C No. _____ Exp. Date _____

You may pay by check or credit card. Please make checks payable to FMA Magazine Program.

NAME OF PUBLICATION	YEARS	PRICE
	TOTAL	

Terms: Subscriptions are one year unless otherwise noted. Prices subject to publishers' changes.
Guarentee: Our prices are the lowest, our service the best.
Renewals: Please send the address label from your magazine at least 8 weeks in advance of expiration date.
New Orders: Publishers take from 8 to 12 weeks to start your subscription.

FLMD786

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

JANUARY

Tenth Annual Oral Pathology Review, Jan. 10-14 and Jan. 31-Feb. 4, Miami. Contact: University of Miami, Division of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

High Risk Pregnancy and Brain Damage, January 15-17, 1987, Sonesta Beach Hotel, Key Biscayne. Contact: Robin Murray (202) 638-5577.

Neurological Update, 1987, Jan. 20-25, 1987, Bal Harbour. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Nineteenth Seminar in Pediatric and Adult Urology, Jan. 21-24, Sheraton Bal Harbour, Miami Beach. Contact: Victor A. Politano, M.D., 6614 Miami Lakes Dr. East, Miami Lakes, 33014, (305) 687-1367.

Introduction to Allergy Diagnosis and Treatment, January 23, Sheraton Orlando Int. Airport, Orlando. Contact: J. Alan Stewart, M.D., (713) 792-5346.

Fourth Annual Doctors Hospital Winter Seminar, Jan. 24-31, Plaza Wood Creek, Mt. Crested Butte, Colorado. Contact: George T. Venis, M.D., 2295 Coral Way, Miami 33145, (305) 856-6121.

Oculoplastic Symposium 1987, January 24-31, University of Miami, Miami. Contact: Univ. of Miami, Dept. of Ophthalmology, P.O. Box 016960, Miami, FL 33101, (305) 964-0707.

Post Convention Seminar on Adult and Pediatric Urology, January 25-28, Nassau, Bahamas. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Interdisciplinary Rape Science Institute, January 25-30, April 5-10, University of Miami, Miami. For more information: University of Miami, Division of CME, (305) 547-6716.

Risk Management for the Pathologist, January 26, University of Miami, Miami. For more info: University of Miami, Division of CME (D23-3), (305) 547-6716.

Tutorial Course of Instruction in Acute Cardiac Care for the Practicing Physician, Jan. 26-31, University of Miami, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Twelfth Annual Review and Recent Practical Advances in Pathology, January 27-31, University of Miami, Miami. For more information contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Annual Meeting of the SSPR, SSCI, Southern AFCR, January 28-30, New Orleans. Contact: John Malone, M.D., (813) 974-4360.

Sixth Annual Perspectives on New Diagnostic and Therapeutic Techniques in Clinical Cardiology, January 30-February 1, Buena Vista Palace Hotel, Lake Buena Vista. Contact: Registration Secretary, Extramural Programs Dept., American College of Cardiology, 1-800-253-INFO.

Tenth Annual Oral Pathology Review, January 31-February 4, San Francisco. Contact: Division of CME (D23-3), University of Miami, (305) 547-6716.

Thirteenth Annual Vail Conference in Anesthesiology, Jan. 31-Feb. 7, Vail, Colorado. For more information: Sonja Craythorne, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101, (305) 547-6411.

FEBRUARY

Current Clinical Concepts in OB/GYN, Feb. 2-4, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Breznen, (305) 650-6236.

Gastroenterology Update, Feb. 7, Mt. Sinai Medical Center, Miami Beach. Contact: University of Miami, Division of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Vail Symposium in Intensive Care, Feb. 7-14, Vail, Colorado. For more info: Sonja Craythorne, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6411.

Advances in Gene Technology, Feb. 9-13, Hyatt Regency, Miami. Contact: William J. Whelan, Dept. of Biochemistry, P.O. Box 016960, Miami 33101, (305) 547-6265.

Cardiopulmonary Rehabilitation Status '87, Feb. 10-14, University of Florida, Gainesville. Contact: Michael Pollock, Ph.D., Dept. of Medicine, Univ. of Florida, JHMHC J-277, Gainesville, 32610, (904) 392-0584.

Communicating with Patients, Feb. 12-13, Tradewinds Hotel, St. Petersburg. Contact: Daivd H. Smith, Ph.D., (813) 974-3294.

Current Topics in Occupational Health, Feb. 16-21, Tampa. For more information: Nicholas Alexiou, M.D., (813) 974-3294.

Conference on the Beach, February 16-21, Daytona Hilton, Daytona Beach. Contact: Tariq Siddiqui, M.D., Halifax Hospital, P.O. Box 1990, Daytona Beach 32015, (904) 254-4167.

Hepatobiliary Disease in the Clinical Practice VII, February 19-21, Bal Harbour. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Bascom Palmer Eye Institute 25th Anniversary Celebration, Feb. 19-21, Fontain Bleau Hotel, Miami Beach. For more information: Gaby Kressley, Dept. of Ophthalmology, P.O. Box 016960, Miami 33101, (305) 326-6031.

National Forum Aids and Chemical Dependency, Feb. 20-21, Royce Hotel, Ft. Lauderdale. Contact: Larry Siegel, M.D., (212) 206-6770.

Tutorial Course in Acute Cardiac Care for the Practicing Physician, Feb. 23-28, University of Miami, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Third Annual Update on Neuro-Oncology, Feb. 24-25, Tradewinds Hotel, St. Petersburg Beach. For more info: S. Phuphanich, M.D., 12901 N. 30th St., Box 69, Tampa, 33612, (813) 974-3771.

Nineteenth Teaching Conference in Clinical Cardiology, Feb. 25-28, Sheraton Bal Harbour, Bal Harbour. Contact: Virginia McCars, Division of Research in Medical Education, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6491.

Selected Aspects of Internal Medicine, Feb. 28-March 6, Colorado, Telluride. Contact: University of Miami, Dept. of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

MARCH

Internal Medicine 1987, March 1-6, Bal Harbour, Division of CME (D23-3), University of Miami, (305) 547-6716.

Three-Day Diabetes Management Course, March 3-5, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Intensive Care for Neurological Trauma and Disease, March 4-8, Walt Disney World, Orlando. For more information: University of Miami, Division of CME (D23-3), (305) 547-6716.

Eleventh Annual Midwinter Seminar in OB/GYN, March 5-7, St. Petersburg. Contact: James Ingram, M.D., (813) 974-2088.

The Heart and Brain Clinical Inter-Relationships, March 9-11, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Breznen, (305) 650-6236.

Advances and Improvements in Hernia Surgery, March 12-14, Hyatt Regency, Miami. Contact: Arthur I. Gilbert, M.D., 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Eighteenth Annual Topics in Internal Medicine, March 12-14, Hilton Hotel, Gainesville. Contact: Craig S. Kitchens, M.D., (904) 375-6247.

Cancer Conference Daytona Beach, March 13-14, Halifax Hospital Medical Center, Daytona Beach. For more information contact: Terry Bloom, M.D., (904) 254-4210.

Advances in Spinal Surgery VII, March 17-22, Bal Harbour. For more info: University of Miami, Division of CME (D23-3), (305) 547-6716.

Trauma Tactics Symposium, March 20-21, Good Samaritan Hospital, West Palm Beach. For more info: Barbara L. Breznen, (305) 650-6236.

Vascular Surgery, 19897, March 22-24, Hilton Hotel, Good Samaritan Hospital. Contact: Barbara L. Breznen, (305) 650-6236.

Diagnosing Dermatology and Infectious Diseases in Pediatrics, March 23-25, Good Samaritan Hospital, West Palm Beach. For more information: Barbara L. Breznen, (305) 650-6236.

Ninth Annual Family Practice Review, March 23-27, Holiday Inn Surside, Clearwater Beach. Contact: Charles Aucremann, M.D., 701 Sixth St. South, St. Petersburg 33701, (813) 983-6156.

APRIL

Pediatric Oriented ACLS Provider Course, April 3-5, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Practical Aspects of Newer Cardiovascular and Renal Therapies, April 5-8, Orlando. Contact: Division of CME (D23-3), University of Miami, (305) 547-6716.

Interdisciplinary Rape Science Institute, April 5-10, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Tutorial Course in Acute Cardiac Care for the Practicing Physician, April 6-11, University of Miami, Division of CME (D23-3), University of Miami, (305) 547-6716.

Issues in Prenatal Care — 1987, April 10-11, Indigo Lakes, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Blvd., Daytona Beach 32014, (904) 252-4701.

Second Congress on Sports Injuries for the Primary Care Physician, April 23-25, Village of Grenelife, Grenelife, FL. Contact: Brian C. Halpern, M.D., (904) 324-6661.

1987 Radiation Therapy Clinical Research Seminar, April 23-25, University Centre Hotel, Gainesville. Contact: Timothy A. Brant, M.D., Radiation Therapy Division, University of Florida, JHMHC J-385, Gainesville 32610, (904) 395-0287.

Miami Comprehensive Review Course in Anesthesiology, April 25-May 2, Key Biscayne. For more information: University of Miami, Division of CME (D23-3), (305) 547-6716.

MAY

Five-day Management of Diabetes Mellitus, May 11-15, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

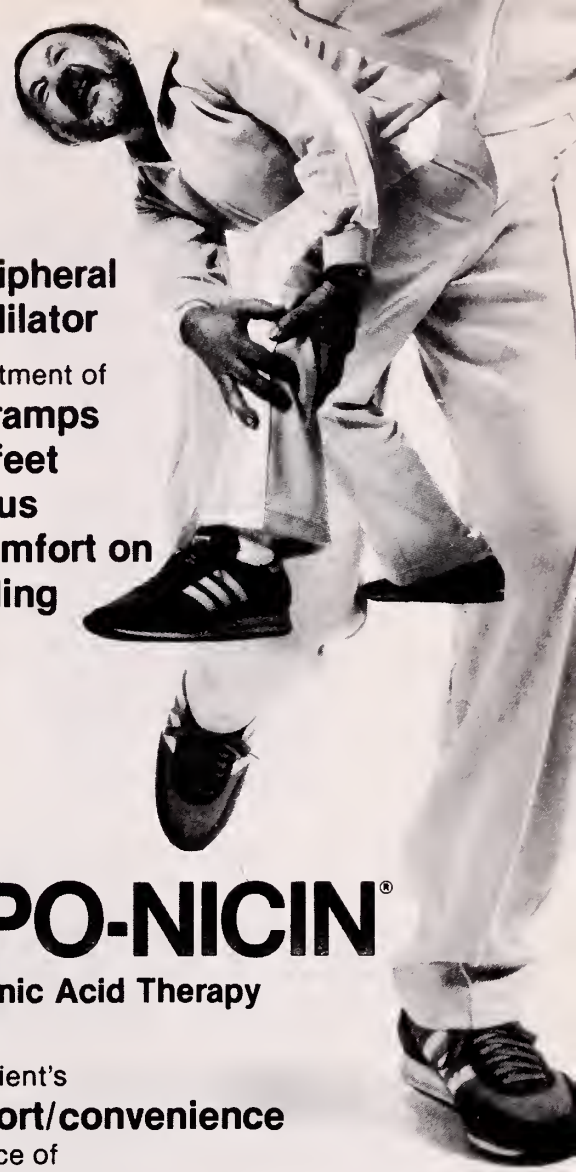
GET MORE FOR YOUR ADVERTISING DOLLAR

Purchase A Display Ad in the

Journal of the Florida Medical Association, Inc.

Send for your ad kit today. Call or Write
Ms. Sissy Crabtree, Managing Editor
P.O. Box 2411
Jacksonville, Florida 32203

(904) 356-1571



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

The Third Annual Update In Neuro-Oncology, 1987

Tradewinds Hotel • St. Petersburg Beach, FL • February, 24-25, 1987

Sponsored by:
Division of Neuro-Oncology, Department of Neurology, University of South Florida College of Medicine, and H. Lee Moffitt Cancer Center and Research Institute and James A. Haley Veterans Hospital

Tuesday, February 24: Afternoon Session
Symposium On: Cancer Pain and Management
Moderator: Shashidhar Kori, M.D.

12:00 p.m.	**Registration**
1:00 p.m.	**Welcome and Introduction** Leon D. Prockop, M.D.
1:05 p.m.	**Clinical Assessment of Patients and Pain Syndromes in Cancer Patients** Shashidhar Kori, M.D.
1:45 p.m.	**Analgesics and Drug Therapy of Cancer Pain** William Dinwoodie, M.D.
2:30 p.m.	**Measurement of Pain and Pharmacokinetics of Analgesics** Robert Kaiko, Ph.D.
3:15	**Refrehsments and Exhibit Display**
3:30 p.m.	**Endogenous Opiates in Management of Cancer Pain** G. W. Pasternak, M.D.
4:15 p.m.	**Psychiatric Aspects of Cancer Pain** Walter Baile Jr., M.D.
5:00 p.m.	**Panel Discussion**
6:00 p.m.	**Cocktail Reception**

Wednesday, February 25: Morning Session
Symposium On: AIDS and Neurological Complications
Moderator: Leon D. Prockop, M.D.

7:30 a.m.	**Continental Breakfast Registration**
8:00 a.m.	**Neuro-Epidemiology of AIDS** Nancy A. Brandenburg, Ph.D.
8:15 a.m.	**Overview: AIDS and ARC Syndrome** John F. Toney, M.D.
8:45 a.m.	**AIDS in Children: CNS Manifestation** Rajendra Pahwa, M.D.
9:15 a.m.	**Infectious Complications in the AIDS Patient** Bienvenido Yangco, M.D.
9:45 a.m.	**Coffee Break and Exhibit Display**
10:00 a.m.	**Neuroimmunology of AIDS** Steven Specter, Ph.D.
10:20 a.m.	**The Impact of AIDS on Neurology and Neurosurgery** Mark Rosenblum, M.D.
11:00 a.m.	**Primary CNS Lymphoma** Fred Hochberg, M.D.
11:40 a.m.	**AIDS: Prospective Research and Future Management** Robert Good, M.D., Ph.D.
12:00 p.m.	**Panel Discussion**
12:15 p.m.	**Lunch and Exhibit Display**

Wednesday, February 21: Afternoon Session
Symposium On: Brain Tumor Therapy
Moderator: Surasak Phuphanich, M.D.

1:30 p.m.	**Brain Tumor Treatment: Then and Now** Michael D. Walker, M.D.
1:45 p.m.	**Brain Tumor Research and Therapy: New Perspectives** Mark L. Rosenblum, M.D.
2:30 p.m.	**Chemo-radiotherapy Interaction in Treatment of Malignant Brain Tumors: High Dose Methotrexate** Werner Bleyer, M.D.
3:15 p.m.	**Refreshment and Exhibit Display**
3:30 p.m.	**MRI/CT Scans in Evaluating Primary Malignant Glioma Following Surgery, Irradiation and Chemotherapy: USF Experience** Surasak Phuphanich, M.D.
4:00 p.m.	**Intracarotid Chemotherapy: MGH Experience** Fred Hochberg, M.D.
4:40 p.m.	**Brain Tumors — The Problem** Michael D. Walker, M.D.
5:20 p.m.	**Panel Discussion: All Faculty**
5:30 p.m.	**Conference Adjourns**

Course Hours: 12 Hours Category 1, AMA
Fees — Scientific Meetings (includes all seminars):
$180.00 — Physicians received before 1/16/87 $100.00 USF Faculty
$250.00 — Physicians received after 1/16/87 $100.00 Residents

For Further Information, Please Contact:
Surasak Phuphanich, M.D., Course Director
Medical Center, Box 69, 12901 N. 30th Street
University of South Florida
Tampa, Florida 33612 (813) 974-3771

Physicians' Confidential Assistance

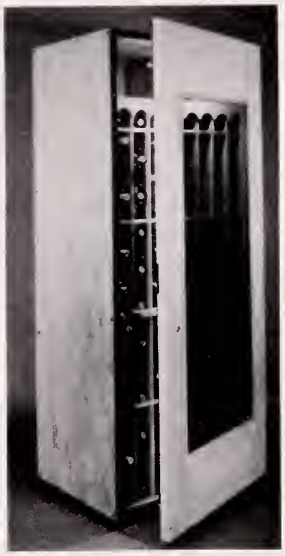
Call (904) 354-3397

. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

L'Humiditemp™

Protect and age your wines in the replicated environment of a subterranean French limestone cave . . . with L'Humiditemp, a product of today's technology.



Automatic humidity/temperature control.
Free standing • 360 bottle capacity • Active odor filtration • Vibration free • Screens out light.
Bottle aeration • Available with Many Options.

800-243-9355 • 617-593-3333
GIRONDE BROS., INC.
319 Lynnway, Lynn, MA 01901

March 18-22, 1987

Breast Disease Update IV

At the Hilton in Walt Disney World Village, Lake Buena Vista, Florida
Sponsored by: **Mount Sinai Medical Center of Greater Miami**

Course Directors
Raul Matallana, M.D.
Victor Dembrow, M.D.
Noel R. Zusmer, M.D.

Guest Faculty
Joseph Allegra, M.D.
Stephen K. Carter, M.D.
Gary M. Clark, Ph.D.
Jay Harris, M.D.
Michael P. Osborne, M.D.
Douglas J. Marchant, M.D.
Laslo Tabar, M.D.

Approved for Category I AMA Credits — 18.0
For further information contact: Mrs. Esther Cohen — (305) 674-2311, Mt. Sinai Medical Center, 4300 Alton Road, Miami Beach, Florida 33140.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word.
Deadline is first of the month preceding month of publication.

Physicians Wanted

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Michelle Parks, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

MEDSTAFF HAS PRACTICE OPPORTUNITIES in an array of Sun Belt locations. Options for locum tenens and/or permanent placements in all specialties. Work fulltime or parttime. Trial associations with established practices also available. Call Virginia Williams at (800) 833-3465 (U.S.) or (800) 672-5770 (NC) or write MEDSTAFF, INC., P.O. Box 15538, Durham, NC 27704.

OPENING FOR RADIOLOGIST: Diagnostic radiologist with interest and experience in mammography and ultrasound needed to staff new radiology office. Monday-Friday, 8-5. Florida License required. Salary negotiable. Contact K. Jay Adcook, M.D., 515 S. Orange Ave., Orlando, FL 32801, (305) 425-1518.

RADIOLOGIST — locum tenens wanted — North Florida practice with possibility of future association. Board qualified. Must have experience in all phases of Diagnostic Radiology including CT and angiography. Send CV with inquiry. C-1355, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST: Opportunity to join multispecialty group in a new and exciting concept of private medical practice in an attractive downtown Tampa office. Please send curriculumvitae to Richard Crane, M.D., 4215 North MacDill Avenue, Tampa, FL 33607, (813) 879-6380.

NEUROLOGIST — Established headache clinic in Tampa expanding, needs BC/BE associate with Florida license to join Senior Neurologist. Excellent practice opportunity for young neurologist with keen interest in headache diagnosis and management. First year salary with incentives leading to partnership opportunity. Send CV and personal requirements to: A. Carvel Gipson, M.D., 2727 W. Buffalo Ave., Tampa, FL 33607.

ASSISTANT MEDICAL DIRECTOR. Part-time, mostly mornings. Familiar with Broward County. Will work in our Miami office, in administrative capacity. Reply to Medical Director, Finlay HMO, 1401 Brickell Ave., Miami, FL 33131.

OTOLARYNGOLOGIST-ENT, Central Fl. Community in Central Florida seeeking ENT (Board Certified or eligible) to establish private practice in affiliation with a multi-specialty group association. Competitive practice, incentive and benefits package. Excellent location for recreational activities, yet close to metropolitan areas. Send CV to Box C-1363a, P.O. Box 2411, Jacksonville, FL 32203.

NEUROLOGIST — (Board Certified/Eligible). Neurologist to establish private practice in affiliation with a multi-specialty group association. Competitive practice, incentive and benefits package. Excellent central Florida location for recreational as well as metropolitan activities. Send CV to Box C-1363b, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE/INTERNAL MEDICINE, BC/BE wanted for rapidly expanding practice. Excellent patient base and unlimited potential to join young internist and GP on FL's east coast. Excellent salary and benefits. Box C-1364, P.O. Box 2411, Jacksonville, FL 32203.

BOARD CERTIFIED FAMILY PRACTITIONER. Growing solo practice needs help. Opportunity for partnership. Immediate opening. Hallandale, FL (305) 458-0100.

CAMP PHYSICIAN: Summer opportunity. Escape Florida heat. Spend up to nine weeks (minimum of three weeks) in outstanding girls camp in Maine. Staff of three R.N.s and Nurse's Aid. Pediatrician or family practice preferred. Excellent salary and housing. Call (301) 653-3082 days, (301) 363-6369 evenings or weekends.

PHYSICIAN: Physiatry, neurology, or anesthesiology specialty wanted for Rehabilitation Facility. Time and office space provided for your own part-time practice. Send resume to P.O. Box 1656, Maitland, FL 32751.

MEDICAL PHYSICIAN: The office of Disability Determination is seeking a Senior Medical Physician to review social security Disability Claims. This position is available in Tampa. Annual starting salary $44,578.00. The qualifications are an M.D. Degree with a license to practice in the State of Florida. Mail application and notice of eligibility to: Office of Disability Determination, P.O. Box 15550, Tampa, Florida 33684. Attn: Ron Atchison, Area Manager, EOE.

FT. PIERCE, FLORIDA — Full time emergency department position available in a 240 bed hospital with an annual ED volume of 24,000. Candidate must be board prepared in emergency medicine. The hospital is centrally located between Disney World and Miami on Florida's Treasure Coast. Excellent compensation and malpractice insurance provided. Please send CV to Cheree Richards, EMSA, 8200 W. Sunrise Blvd., Plantation, FL 33322, or call (305 472-6922.

FAMILY PRACTICE Physician or internist needed for multi-specialty group in Central Florida. Primarily adult and industrial medicine. Florida license is required. Guaranteed income for first year with benefit package, then opportunity to join the corporation. Shared on call schedule with each on call one night per week and every fifth week-end. Send resume to P.O. Box 568908, Orlando, FL 32856-8908.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

GENERAL INTERNISTS, FAMILY PRACTICE, GERONTOLOGIST, EMERGENCY CARE MEDICINE, PEDIATRIC SURGEON, PLASTIC and RECONSTRUCTIVE SURGEON, 40 physician multi-specialty Group in West Palm Beach, Florida seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send C.V. to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 North Olive Avenue, West Palm Beach, Florida 33401.

OPPORTUNITIES AVAILABLE for two psychiatrists — 1) General Adult Psychiatrist; 2) Child and Adolescent Psychiatrist. Board Certified/Board Eligible. Rapidly growing interdisciplinary private practice. Located in Winter Park, Florida. Affiliated with numerous facilities in the Orlando area. Possible positions for directorships and future opportunity for partnership. Must be able to work as a team member. Good salary and benefits. For further information contact: the Group for Psychiatry,

Psychology and Social Services, 335 N. Knowles Ave., Winter Park, FL 32789 (305) 644-2121.

INTERNAL MEDICINE:Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

OBSTETRICIAN-GYNECOLOGIST, Board eligible or board certified, male or female, American or foreign trained, to join well-established practice ijn progressive community of 20,000 in eastern North Carolina with a service area of 100,000, close to Raleigh and Durham, North Carolina, and Richmond and Norfolk, Virginia. Area has excellent cultural and recreational activities. School system is among the best in the state. Excellent benefit package. Send curriculum vitae to P.O. Box 1122, Roanoke Rapids, N.C. 27870 or call collect (919) 535-2200 Monday-Friday 9 a.m.-5 p.m. or (919) 535-2273 evenings and weekends.

PSYCHIATRIST — full-time position open for Board Certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient and limited inpatient on-call. Florida license needed. Reply to Box C-1349, P. O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTITIONER: Progressive Community seeking qualified physician for full family practice setting. Beautiful lake area, 20 miles from Gainesville, Florida and hospitals. Tri-county area with expanding population and growing medical community. Ample office space available at reasonable rates. Please contact or send resume to Laura S. Hodges, P.O. Box 1099, Melrose, FL 32666 or call (904) 475-3113.

PSYCHIATRIST needed at West Florida Community Care Center, a 68-bed adult, residential psychiatric hospital. Located 20 miles east of Pensacola, near Gulf Coast Beaches. Annual salary $65,000. Thirty hour week. Florida license (or eligibility) required. Send Vita to Dr. DeSonier, Adm., 400 Stewart St., Milton, FL 32570 or call (904) 623-4990, EOE.

TAMPA, FLORIDA — Excellent opportunity to become the primary physician of a well established growth oriented Family Practice in the fastest growing city in the South. Practice benefits include association with a specialty group, computerized management system, X-ray, Laboratory, Spirometry, modern offices in pleasant surroundings. We are seeking a Board Certified or Board Eligible Family Practitioner, highly motivated and dedicated to the delivery of quality health care. Excellent base salary plus strong incentives based on revenues. We will provide assistance with interview and relocation expense. If you would like to be an important part of our growing team, send your C.V. to John Q. Stauffer, M.D., 2919 Swann Avenue, Suite 205, Tampa, Florida 33609; or call (813) 870-3971.

WANTED IMMEDIATELY: Young aggressive physician for growing Winter Haven walk-in clinic. Call Dr. Casebolt at (813) 299-8485.

EMERGENCY MEDICAL GROUP, a progressive, physician owned association is seeking Full and Part-time Board certified/eligible Emergency Medicine, Internal Medicine and Family Practice physicians for openings in Southeast Florida. Competitive salary, paid malpractice insurance, benefits and attractive scheduling. Send CV to Emergency Medical Group, 1400 N.W. 12th Ave., Miami, FL 33136.

WELL ESTABLISHED, three physician family practice is seeking a qualified associate for SW area of Miami. The practice is equipped with laboratory and X-ray facilities. Please Contact or send resume to: Drs. Burley, Skeen & Guaty, PA, 9621 Bird Road, Miami, FL 33165 (305) 221-3111.

CARDIOLOGIST: Unique, golden opportunity for Board Certified/Board Eligible Cardiologist-Internist. Rapidly growing cardiology practice Southeast Florida. Twenty years experience required. Salary: Six figures start. No administrative headaches or worries. No partnership. Please respond with CV, Box 30313, Palm Beach Gardens, FL 33410.

WANTED: OSTEOPATH or physical M.D. looking to set up a practice in conjunction with busy chiropractic clinic in east central Florida. Looking for someone interested in joint rehabilitation, personal injury work, or a wellness center. Will share modern cineradiography equipment. Send resume to Braile Chiropractic Life Clinic, 839 Barton Boulevard, Rockledge, Florida 32955; or contact 305-636-5200.

TIRED OF HMOs? Conduct your specialty or primary care practice in a traditional setting in a growing community south of Ocala. Demand for all specialties exceeds supply (AMA market profile available). The new Mockingbird Hill Professional Center is now open with lease/purchase option. Opportunity now exists for custom interior design. Lab and x-ray on-site and private ambulatory care center provides a referral base. Only 10 minute drive to HCA hospital. For information call or write Sharon Flynn, Ellison Realty, Inc., 2226 E. Silver Springs Boulevard, Ocala, FL 32670 or 694-6443 (eves.).

FAMILY PRACTICE OR INTERNAL MEDICINE: Immediate full-time positions available with national correctional health care firm. Board eligible or certified preferred. State License and malpractice insurance required. Excellent professional opportunity and competitive compensation package. Respond with curriculum vitae to: Jackie Moore, Prison Health Services, Inc., 1200 Philadelphia Pike, Wilmington, DE 19809.

VARIOUS SPECIALISTS NEEDED for medium size fast growing community in Central Florida. Write Box 1370, P.O. Box 2411, Jacksonville, FL 32203.

BOARD CERTIFIED GENERAL SURGEON, as associate, private practice in Orlando. Send CV, references, photo to Box C-1366, P.O. Box 2411, Jacksonville, FL 32203.

DO YOU WANT TO SHARE a thriving dermatology practice? Do you enjoy year around outdoor recreation? You should contact us . . . a progressive multispecialty group of 68 physicians in a pleasant, growing community. We offer a liberal financial package and outstanding benefits. Send curriculum vitae and references to: Michael T. Anderson, M.D., Willmar Medical Center, 101 Willmar Avenue, Willmar, MN 56201.

Situations Wanted

GENERAL AND VASCULAR SURGERY with endoscopic experience. Now a chief resident in a university program. Available July, 1987. Desire solo, partnership, or group practice opportunity. C-1352, P.O. Box 2411, Jacksonville, FL 32203.

AUSTRALIAN FAMILY PRACTITIONER holding FL license and British MRCP in internal medicine wishes to join family practice in Orlando. Arriving in Orlando early January. Use local contact Mrs. J.D. Mahaffey, 747 Jamestown Drive, Winter Park, FL 32791.

GENERAL PRACTITIONER, female with active Florida license, FMGEMS, FLEX, nine years of hospital practice in India and four years of clinical experience in USA, seeking a salaried position or to associate with a solo practitioner or group in Florida. Available immediately. Please respond to Obiliesetty, M.D., 48 East Kingsbridge Road, Bronx, NY 10468 or call (212) 733-0528.

PEDIATRICIAN: Young, Yale-trained, seeking position in S. Florida for 7/87. Fluent Spanish/English. Flexible interests range from EM to HMOs. Enthusiastic, hardworking. Contact: Sandra Castro, M.D., 111 Park Street, New Haven, CT 06511.

GS/GP 20 years plus experience active solo practice at present. Wish to relocate. 1978 Florida license desires hospital surgical assistant or office based practice. Minor surgery — ?? — endoscopy, etc. 118 Main St., Reedsburg, WI 53959. Telephone 608-524-6451, home 608-524-4423.

RADIOLOGIST, board certified, 35, wishes to relocate in Florida in fall of 1986, prefer private practice. Proficient in diagnostic imaging (CT/US) and angiography, some nuclear medicine. Reply to: R.W. Stone, M.D., 5597 Seminary Road, Falls Church, VA 22041.

Practices Available

TAMPA. ACTIVE FAMILY MEDICINE/GERIATRIC medical practice available with fully equipped office. North Tampa area. Physician retiring. Will negotiate terms and introduce. C-1354, P.O. Box 2411, Jacksonville, FL 32203.

PRACTICE FOR SALE: On busy corner thoroughfare. Sixteen years in practice. Family practice with general surgery. Office complete with lab facilities, including EKG, X-rays, spirometry, etc. Terms negotiable. Available immediately. Northeast Florida. C-1360, P.O. Box 2411, Jacksonville, FL 32203.

DERMATOLOGIST PRACTICE FOR SALE: Fully equipped beautifully furnished offices in prestigious doctors building ideally located. Assist in turnover. Great opportunity. Dr. J.J. Eller, 2601 N. Flagler Drive, West Palm Beach, FL 33407. (305) 832-4109.

PEDIATRICS: North Florida. Well-established practice. Will phase out. Equipment available. Building for rent or sale. Pay off over 10 years. C-1359, P.O. Box 2411, Jacksonville, FL 32203.

WEST PALM BEACH — One or more M.D.'s to take over established Pediatric Practice. Located in prime area — 8 room furnished office, equipped laboratory and supplies. Rent or buy. Terms negotiable. Reply — P.O. Box 3344, West Palm Beach, FL 33402.

PEDIATRICIAN planning to retire. Seventeen-year-old solo practice for sale. 2178 square foot office building for sale or lease. Jacksonville Beaches Area. (904) 249-4570 or 241-7113.

UROLOGIST retiring due to illness desires to sell 18-year-old solo practice. Also available: office building suitable for two physicians. Jacksonville Beaches area. (904) 249-4570 or 241-7113.

ESTABLISHED GYNECOLOGICAL practice with potential for tremendous growth in rapidly developing area of Tampa, FL. Perfect for new practice for 1 or 2 ob/gyns or for relocating ob/gyn. Practice has over 4000 patients, excellent reputation. Call (813) 985-5253 or write WomenCare 11404½ N. 56th St., Tampa, FL 33617.

FAMILY PRACTICE near Melbourne, FL. Excellent schools and recreation. Young patient profile. Gross over $150,000. Must sell by July, 1987. Edward R. Boyle, M.D., 4620 Lipscomb ST., NE Unit 1, Palm Bay, FL 32905. (305) 725-9800.

Real Estate

SPRING HILL, FL - 2300 square foot professional office space in modern new prestigous building with prime exposure. For sale or lease - owner will finance. (904) 596-4162 weekdays.

RETIRING BOARD CERTIFIED OB-GYN selling or leasing completely equipped office. Capacity for 2 or more Ob-Gyns. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone 305-667-3677.

SALE/LEASE — Medical Imaging facility, Ft. Lauderdale. Building and Equipment. Turn Key. Siemens-Kodak-Technicare, plus additional equipment space. Herman E. Rolfs, M.D. (904) 863-8110.

SALE MEDICAL BUILDING: 6 suites, 10,000 sq. ft. Fully leased prime corner location. Excellent terms available. For complete information package on this property contact J. Besse or M. Ballard, Merill Lynch Realty (305) 841-6060.

FOR LEASE: Office space available in multi-specialty medical colmplex. From 943 sq. ft., to 1600 sq. ft. Central location close to hospitals. Rapidly growing area, in Brevard County. C-1367, P.O. Box 2411, Jacksonville, FL 32203.

CRESCENT PLAZA — Located on AIA St. Augustine Beach, FL. Excellent location for medical office or health clinic in fast growing area, near hospitals. Contact Helen Marett, (904) 824-0491 or 824-4306.

FOR RENT — Miami Beach office in exclusive and prestigious medical building. Within Mount Sinai, Miami Heart and St. Francis area. Call T.G.R. Services, Inc., Realtors at (305) 284-1035.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

WE BUY, SELL, LEASE SERVICE new and preowned medical instrumentation: Holter-Stress-Ultrasound-EKG Lab etc. Contact New Life Systems, Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065; 305-972-4600.

LONG TERM FINANCING for starting/purchasing practices, diagnostic centers, equipment, office condos, buildings. $25,000 to $1,000,000. Western Financial, 1380 Miami Gardens Drive, N. Miami Beach, FL 33179, (305) 949-5900.

Equipment

WORD PROCESSOR — SONY. Take over lease - no downpayment, series 35 partial page, dual disk drive, 55 CPS printer. 14 months on lease at $730 per quarter. Option to purchase/investment tax credit. C-1357, P.O. Box 2411, Jacksonville, FL 32203.

HOLTER MONITOR: Quality scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretation, scan price $35.00. Recorders loaned, leased or purchase new dual-channel holter recorder, $750.00 with two year warranty. For more information call collect, Advance Medical & Research Center, Inc., 1-313-373-1199.

FOR SALE: Medical Equipment and supplies, including QBC blood analyzer, A-O microscope, Burdick EK-100 EKG, defibrillator, hyfrecator, x-ray duplicator, view boxes, shelving, miscellaneous instruments, office and medical supplies. Package deal. Box C-1361, P.O. Box 2411, Jacksonville, FL 32203.

35-CM SIGMOIDOSCOPE, Flexible-Fiberoptic, Brand new, FPS-3 American Optical/ Reichert, Price: $945.00. (305) 994-2260 day or 994-6950 evening.

SALE/LEASE Medical Imaging Facility, Fort Lauderdale — Building and Equipment. Turn Keyl. Siemens-Kodak-Technicare plus additional equipment space. Herman E. Rolfs, M.D. (904) 863-8110.

FOR SALE — Family physician's examining room and business office furniture and equipment. Priced for quick sale. Includes two Midmark table and Cannon copier.

OPHTHALMOLOGIST retiring, selling Axisonic II Jedmed recently recalibrated by teknar in original shipping carton $3500. Complete microsurgery instruments including corneal transplant trephines offered at half replacement cost (904) 829-2753, 824-1767.

Meetings

1987 CME CRUISE/CONFERENCES on selected medical topics — Caribbean, Mexico, Hawaii, Alaska, China/Orient, Scandinavia/Russia. 7-14 days year round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) and AAFP prescribed credits. Distinguished professors. Fly roundtrip free on Caribbean, Mexican & Alaskan cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746 (516) 549-0869.

BIOFEEDBACK THERAPIST TRAINING WORKSHOP — Four day program to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. Medical CEUs pending. September 25-28 or November 13-16, 1986. Tentative 1987 dates: February 6-9, April 24-27, or June 12-15. For brochure contact: Hartje Stress Clinic, 2429 University Blvd. West, Jacksonville, FL 32217. (904) 737-5821.

Miscelleneous

MEDICAL-APOTHECARY antiques and collectibles for sale. Huge assortment of 1800s to early 1900s items. Visit the Medical Corner, Hollywood Antique Mall, 2031 Harrison St., Hollywood, FL 33020 (305) 922-6255.

Index to Volume 73
January-December, 1986

Annual Meeting:
Index to Proceedings 908-12

Auxiliary Page:
Acquaint Yourself with Auxiliary Programs 559-7
AMA Auxiliary Convention Creates Motivation 645-8
AMA-ERF Supports Quality Medical Education and Health Care 65-1
Auxilians Cared in 1986 717-9
Bradford County Auxilians Provide Comfort for Nursing Home Residents 1043-12
Chemical Dependency 137-2
The FMA Auxiliary is a Total Way of Life 807-10
The March on Tallahassee 483-6
Missing Children Posters Program Started 345-4
We Care . . . In Many Ways 417-5
What is Doctors' Day and Why Observe It? 235-3
Windflowers of the Tropics Aid AMA-ERF 887-11

Book Reviews 231-3; 415-5; 553-7; 643-8; 715-9; 803-10; 885-11

Classified Advertisement: 72-1; 148-2; 240-3; 350-4; 424-5; 490-6; 568-7; 652-8; 724-9; 814-10; 894-11; 1050-12

Correction 343-4; 479-6

Issue on Contraception:
Contraception and the Law: Medical-Legal Trends Affecting Availability of Contraception in the United States 777-10
Nonsteroidal Contraception — Alternatives to the Pill 773-10
Oral Contraceptives — An Overview 763-10
Oral Contraceptives — The Long-Term Perspective 769-10
Unintended Pregnancy — A U.S. Problem 760-10
Update on Contraception 759-10

Deans Message:
A Case for Example 636-8
Biomedical Research at the University of Miami School of Medicine — A Brief But Successful Report 880-11
The Clinical Clerkship: An Endangered Species 131-2
Current Dilemmas Facing Medical Students 1038-12
The Declining Interest in Medicine: A Major Concern 710-9
The Flexner Report and the Issue of Faculty Roles 796-10
New Curriculum Proposal for the University of Florida 408-5
Teaching the Socioeconomics of Medicine 474-6
Our Younger Colleagues 54-1
Student Medical Involvement Essential To Organized Medicine 338-4

Deaths 140-2; 562-7

Editorials:
The Alamo Syndrome — Is It the Duty Of Physicians to Ride to the Rescue? 672-9
A Hospice Christmas 916-12
An Invitation to *Journal* Readers 97-2
The Brown Bag Syndrome — A Deadly Epidemic 172-3
The Bottom Line 366-5
DRGs and the New Patients' Bill of Rights 171-3
The Drug Problem: Tilting With Windmills 589-8
Ethics in Medicine 835-11
Freedom to Practice Slipping Away 831-11
Getting Tough on Incompetent Physicians 507-7
James B. Perry, M.D. 745-10
Jury Awards $24 Million in Challenger Malpractice Case 174-3
Language Pollution in Medicine 671-9
Let Us Stand Together 14-1
The Liability Crisis: 1986 and Beyond 12-1
Liability Reform: It Is Now The Legislature's Move 261-4
Life Is Not a Spectator Sport 11-1
Medicare in Troubled Waters 587-8
Meet Jim Perry 746-10
The Need to Reform Indigent Care 918-12
Peddling the Goods 917-12
Physicians' Fees: What's Ahead? 365-5
Physicians' "Rebates" — Incentive Or Bribery? 13-1
Put Them On the Flanks — And Watch 'Em, Watch 'Em? 508-7
Quality of Care in Jeopardy 95-2
Responsible Reporting or Yellow Journalism? 367-5
The Shame of Nursing Homes 441-6
Some Thoughts on Graduation 443-6
Thoughts on Thanksgiving 833-11
The 112th Annual Meeting of the Florida Medical Association 747-10
Turning the CME Corner 262-4
UCR Fee Schedule: The Moral Dilemma of It All 749-10
Warning: More Lawsuits Ahead, but Solution in Sight 510-7
Where Do We Go From Here? 915-12

Encores!:
A Florida Physician's Testimony to the U.S. Senate on the Malpractice Problem 549-7
Bread Upon the Waters 797-10
Business Barracudas Feeding on Doctors 56-1
Capitation Helping Win War Against High Cost of Health Care 409-5
Caveat, Doctor 1039-12
The Dangers of Professional Pressure 798-10

Dial-A-Lawyer 224-3
Doctors and Stress: Is There Really A Problem? 340-4
Heinz Report Bares DRG Flaws: Recommendations Compound Them 132-2
The Hippocratic Oath — Corporate Version 132-2
H M Oh No! 1041-12
Imagine a Doctor Having to Take a Salary Cut to Get a Job — It Could Happen and Sooner Than You Think 411-5
In Search of Eloquence 881-11
It Is Still a Privilege to Be a Doctor 412-5
Is It Time to Raise the Rates? 637-8
La Vida No Vale Nada 799-10
Lawyers Don't Have a Moral Leg to Stand On In Insurance Crisis 339-4
Legible, Literate, Lucid 225-3
Let's Discuss a National Health Service 882-11
Lunar Madness 475-6
The National Lottery 223-3
O-Ring Syndrome 711-9
Point of View: Technology and the Experimental Boundary 54-1
Respiratory Hazards of Anti-Static Clothes Softener 342-4
The Search for Available Insurance: Where Is It? 57-1
Selling Surgery 548-7
Ten Commandments for Proper Prescribing (From the Committee on Drug and Alcohol Abuse, Medical Society of New Jersey) 713-9
The Tragedy of Ham Let, Heir of Hippocrates 713-9
Utilization Review Can Curb Costs While Retaining Freedom of Choice 226-3
Where the Dollars Are — or Were 60-1
We Need Doctors We Can Pay Less and Boss More — Namely, Women 476-6
When to Treat Mild Hypertension 477-6

Historical Issue:

A Local Public Health Experience — History of the Palm Beach County Health Department 276-4
The Best of Both Worlds: General Practice in Rural Florida, 1928-1950 312-4
Development of the Florida County Public Health Unit System 286-4
The Great Typhoid Epidemic in Florida, 1898 289-4
Guest Comments — *JFMA* Historical Issue 273-4
History of Tuberculosis In Florida 305-4
Hookworm Eradication Program of Florida in the Early 20th Century 300-4
Indigent Care and Public Health in Florida, 1931-1985 230-4
Mosquito Control — Its Impact on the Growth and Development of Florida 310-4
Our Debt to Public Health 274-4
Our Medical Heritage — A Synopsis of the Discipline of Medical Practice in Florida 321-4
Who Killed Cock Robin? 317-4

Interim Meeting:

First House of Delegates 197-3
Remarks of the President 199-3
Remarks of the Speaker of the House 198-2
Second House of Delegates 203-3
Report of Reference Committee No. I 205-3

Letters and Viewpoints 19-1; 99-2; 179-3; 267-4; 371-5; 513-7; 593-8; 677-9; 753-10; 839-11; 921-12

Medical Economics:

A Reply to Dr. Caldwell 332-4
Dr. Caldwell's Reply 334-4
The Elements of Power 215-3
The Elements of Power 329-4
Health Maintenance Organizations: 1986 Update 541-7
Marketing of Medical Services 47-1
Messages from Machiavelli 789-10
Peer Review Organizations: What Is the Record So Far? 465-6
Physicians and the Challenge of Politics 871-11
Physician Contribution to Indigent Care The Experience of Volusia County 129-12
Physician Reimbursement for Medicare Beneficiaries (II): Implications of Regional and National Fee Schedules 627-8
Proposals for Capitation Reimbursement of Physician Fees 401-5
Should Florida Physicians Embrace Medical Trade Unionism? 123-2
Unionism: An Inappropriate Treatment for Medicine's Ills 124-2

Meetings 68-1; 144-2; 238-3; 348-4; 420-5; 486-6; 566-7; 648-8; 720-9; 810-10; 890-11; 1046-12

Notes and News:

ACEP Begins Series on Reducing Malpractice Risks 547-7
ACP Physicians Network to Monitor Community Medical Practices 795-10
A. Jay Block, M.D., Named ACCP President-Elect 879-11
AIDS Brochure Available Through Hospital Association 54-1
An NIH Consensus Development Conference on the Impact of Routine HTLV-III Antibody Testing On Public Health 337-4
Annual Meeting Program Correction 880-11
112th Annual Meeting Scientific Program 632-8
1986 Annual Meeting Scientific Program Begins To Take Shape 337-4
Chernobyl Bone Marrow Transplant Expert To Brief U.S. Physicians Via Video 631-8
Clinicians Prescribe Multiphasics for New Patients More Often Than Any Other Oral Contraceptive 1037-12
Costs Up, Access Threatened OB/GYN Study Shows 407-5
Decreasing Trend of Both Reye Syndrome and Aspirin Use Supports Hypothesis of Link Between the Two: Study 53-1
Dr. Hanley Appointed to *JFMA* Editorial Staff 222-3
Dr. Jack Hickman Dies 879-11
Exercising Testing Report Released 796-10
Florida Medical Drug Utilization Review Program 222-3
FMA Testifies on Delay in Medicare Reimbursement 473-6
Historical Issues Needed 222-3
Hospital Admissions Still Declining 709-9
Hospital Association Offers Free Hurricane Preparedness Brochure 632-8
IAG Accepting Entries for Sandoz Gerontology Prize 631-8
Incidence of Cesarean Sections Higher in Florida Than in the Nation 547-7
JCAH Publishes the 1986 Accreditation Manual for Hospitals 53-1
Joint Commission Announces New Corporate Report 222-3
Joint Commission Emphasizes Education, Technical Assistance in New Division 709-9

Joint Commission Makes Substantial Change in Standards Development Process and Monitoring Process 129-2
Medical Education and Physician Supply in the South: Dramatic Changes and Challenges 130-2
Miami Children's Hospital Creates Hall of Fame 337-4
National Institute of Aging Directory Published 879-11
National Philanthropy Recognizes Eye Care Helpline for Elderly 632-8
Pfizer Hospital Products Group Announces Grant for Innovation 473-6
Physicians Needed by Department of Corrections 547-7
Schedule of 112th Annual Meeting Scientific Program 547-7
"Shortness of Breath" Film Discusses Common Concerns 221-3
Southeastern Conference on Addictions 130-2
Southern Health Association Annual Education Conference 473-6
University of Florida Announces Expanded Hospital Board of Directors 408-5
USF Announces New Endowed Chair 221-3
1987 Southeast Leadership Conference 1037-12

President's Page:
A Step in the Right Direction 437-6
April 21st — A Day in the Right Direction 93-2
The Challenge Continues 505-7
The Fight Is Not Over 363-5
1986 Legislative Session Holds Many Challenges 169-3
FMA: Working to Ensure Future Success for Florida Physicians Insurance Reciprocal 9-1
Listening to the Christmas Message 911-12
Medical Ethics 741-10
Sovereign Immunity 827-11
Transitions in Leadership: Unity in Purpose 585-8
Unity is the Key 257-4
Warm Farewell 667-9

Scam of the Month 61-1; 135-2; 227-3

Scientific Articles:
Acquired Immunodeficiency Syndrome (AIDS) Associated With Blood Transfusion: A Review of Literature and Report of Two Cases From Dominican Republic and Haiti 107-2
Adenocarcinoma of Small Intestine (25 Year Review — Roswell Park) 526-7
Advances in Medical Fraud: Chelation Therapy Replaces Laetrile 681-9
Cardiac Surgery in High Risk Octogenarians — Is It Feasible? 447-6
Cardiac Transplantation 111-2
Cardiac Transplantation: The First Year's Experience at the University of Florida — Shands Hospital 849-11
Clinical and Radiological Aspects of the Superior Mesenteric Artery Syndrome 686-9
Comparison of Pre-Operative Endometrial Sampling With Operative Specimen Histology 451-6
Efficacy of Cryotherapy in the Treatment of Human Papilloma Virus Infection of the Uterine Cervix 188-3
Laser Therapy of Primary Lung Cancer 25-1
Low Back Pain, Sciatica and Chemonucleolysis: A Community Hospital Experience 185-3
Magnetic Resonance Imaging of Postdiscogram Discitis and Osteomyelitis in the Lumbar Spine: Case Report 192-3
Meniere's Disease 377-5
Nontypable Hemophilus Influenzae Infection of a Congenial Bronchogenic Cyst 454-6
Neurosarcoidosis Presenting as an Intracranial Mass 35-1
Posttransfusion Purpura — A Rare Manifestation of Blood Transfusion 381-5
Seizures and Action Myoclonus After Occupational Exposures to Methyl Bromide 691-9
Severe Post-TURP Syndrome in Patient With Renal Insufficiency: Treatment With Hemofiltration 384-5
Soft Tissue Infections in Florida Due to Marine Vibrio Bacteria 29-1
The Single-Unit Transfusion 855-11
"Sting" of Puss Caterpillar, *Megalopyge opercularis* (Lepidoptera: megalopygidae): First Report of Cases From Florida and Review of Literature 521-7
Survey of Raccoon Hunters for Rabies Anitbody Titers: Pilot Study: 517-7
Thymoma Associated With Lupus Syndrome and Associated Findings of Pulmonary Sequestration 114-2
Treatment of Sickle Cell Disease with Danazol 847-11

Special Articles:
A Review of the New Statutory Changes in Florida Governing the Policy of Obtaining a Medical License by Examination 783-10
Barriers to Effective Medical Discipline and Some Possible Solutions 861-11
Changing the Rules 119-2
Confessions of Would-Be Health Care Entrepreneur 536-7
Democracy and Health Care — Trends in Three Kindred Western Nations: Britain, Canada, and the United States 695-9
Legality of Physician Referral of Patient to Health Care Facilities Owned by Referring Physician 701-9
Medical Eye Care by Optometrists: Retrospective Review 1977-1983 390-5
New Rules Link to CME to Licensure Renewal 866-11
On the Brink of Disaster — The Divergence of American Culture and American Medicine 621-8
Physician Payment Plans and Conflicts of Interest 387-5
Prison Health Care: Problems and Alternatives in Delivery of Health Care to the Incarcerated — Part I 531-7
Prison Health Care: Problems and Alternatives in Delivery of Health Care to the Incarcerated — Part II 615-8
Underground Medicine: The Widening Problem of Unlicensed Problem of Unlicensed Physicians in the United States 459-6
When Should the Sick Doctor Stop Caring for Patients, and Who Will Make That Decision? 43-1

Special Issue on Sports Medicine:
Sports Medicine: A Growing Specialty 599-8
Ocular Injuries in Sports 600-8
Effects of Exercise in Diabetes Mellitus 603-8
The Benefits and Reproductive Risks of Exercise to Women 605-8
Overuse Syndrome 607-8
Athletic Injuries Caused by the New Sport of Windsurfing and a Proposed Set of Preventive Measures 609-8

Authors

Acosta-Rua, Gaston J., Jacksonville 549-7
Adams, David P., Gainesville 312-4
Ahn, Yeon S., Miami 847-11
Altenburger, Karl M., Ocala 713-9
Ameen, John, Jacksonville 451-6
Ames, Donald L., Vero Beach 607-8
Applegate, C. William, Tallahassee 797-10
Arrington, John A., Tampa 192-3
Babcock, Kenneth B. Washington, D.C. 745-10
Badby, Richard J., Winter Park 798-10
Barrineay, Charles, Palatka 381-5
Barry, Bill E., Tampa 799-10
Baumgartner, Donald L., Wheeling, IL 521-7
Becker, Robert J., Joliet, IL 226-3
Bedoya, Ricardo, Lake City 686-9
Benrubi, Guy, Jacksonville 188-3; 451-6
Bertolette, Mrs. Randall deB. (Sue), Vero Beach 65-1; 887-11
Black, David, Gainesville 517-7
Bloom, John D., Ft. Lauderdale 746-10
Bognolo, Diego A., Tampa 447-6
Botero, Ernesto, Maryland 35-1
Bouis Jr., Pierre J., Tampa 866-11
Bowen, Otis R. 409-5
Brennaman, Bruce, Gainesville 29-1
Brumback, C.L., West Palm Beach 276-4
Cahill, David W., Tampa 35-1
Caldwell, Jacques R., Daytona Beach 47-1; 124-2; 215-3; 329-4; 334-4; 401-5; 465-6; 541-7; 627-8; 789-10; 871-11; 881-11; 1031-12
Campbell, David A., Gainesville 338-4
Carmichael, Michael J., Gainesville 111-2; 849-11
Case, Ronald W., Tampa 390-5
Chandler, Keith W., Tampa 25-1
Collins, Clyde M., Jacksonville 11-1; 833-11; 917-12
Conn, James K., Tallahassee 225-3; 366-5
Connar, Richard G., Tampa 25-1
Conti, C. Richard, Gainesville 111-2
Cox, William W., Daytona Beach 321-4
Crane, David L. Sanford 286-4
Deal, William B. Gainesville 54-1; 408-5; 710-9
Devlin, John T., Burlington, VT 603-8
Dickens, Mrs. W. Jackson (Elaine), Sarasota 345-4
Domen, Ronald E., Tampa 855-11
Doxanas, Marcos T., Vero Beach 600-8
Eckstein, Paul F., Tampa 447-6
El-Mallakh, Rif S., Farmington, CT 521-7
Eisenberg, Carola, Boston, MA 412-5
Falcone, Steve, Miami 1038-12
Fares, Naguib, Hudson, IL 521-7
Farmer, H. Frank, New Smyrna Beach 13-1; 172-3; 274-4; 300-4; 367-5; 508-7; 621-8; 672-9; 749-10; 917-12
Feinstein, Richard J., Miami 43-1; 119-2; 387-5; 459-6; 536-7; 695-9; 783-10; 861-11; 919-12
Fernandez, Michael S., Tampa 773-10
Fischer, Lee A., West Palm Beach 12-1; 56-1; 174-3; 510-7; 747-10
Fogel, Bernard J., Miami 880-11
Fore, Robert C., Jacksonville 262-4; 866-11
Frohlich, Edward D., New Orleans, LA 477-6
Gerber, Mrs. S. Bruce (Priscilla), Winter Haven 235-3
Gibbs, Charles P., Gainesville 408-5
Goodman, Ellen 475-6
Goldman, Allan L., Tampa 25-1

Habal, Mutzal B., Tampa 609-8
Hall, Arthur L., Maitland 332-4
Harrell Jr., Henry L, Ocala 14-1; 443-6
Harrington, William J., Tampa 847-11
Harrison, Eric E., Tampa 447-6
Holmes, Kay, Jacksonville 188-3
Howard, Richard, Gainesville 29-1
Howell, James T., Tallahassee 273-4
Issacs Jr., John H., Gainesville 377-5
Jackson Jr., Russell E., Jacksonville 280-4
Jeffrey, Diane L., Tampa 447-6
Kirdnaul, Amnath, Lake City 686-9
Kirkconnell, Waite S., Tampa 390-5
Klapper, John H., Tampa 454-6
Lacsamana, R.G., Daytona Beach 95-2; 97-2; 171-3; 261-4; 365-5; 441-6; 507-7; 587-8; 589-8; 671-9; 831-11; 915-12
Lagman, Sergio M., Lake City 686-9
Lammert, Nancy, Jacksonville 188-3
Laude, Mrs. Walter (Isabella) 1043-12
Lieb, Spencer, Gainesville 29-1
Lieberman, Eric, Miami 1038-12
Lima, Mrs. Marcos (Susan), Leesburg 417-5
London, Rose E., Miami Beach 1040-12
Manni, L.C., Tallahassee 305-4
Margo, Curtis E., Tampa 548-7
Marks, Mrs. V.A. (Susan), North Palm Beach 807-10
May, Robert D., Hudson 317-4
Mayer, Gabriel, Orlando 114-2
McCammon, Robert E., Tampa 760-10
McCue, Jack D., Winston-Salem, NC 340-4
McDonald, John W., Vero Beach 599-8
Meeks, G. Rodney, Jackson, MS 605-8
Miles, Mrs. Clifford B. (Nancy), Pompano Beach 137-2
Mokris, Michael, Gainesville 377-5
Montgomery, Mark R., Tampa 681-9
Moore, Charles E., Tallahassee 711-9
Moore, Jacqueline M., Wilmington, DE 531-7; 615-8
Mulrennan Jr., John Andrew, Jacksonville 310-4
Murtagh, F. Reed, Tampa 192-3
Musunuru, S.K., Hudson 447-6
Nocero, Michael, Orlando 114-2
Nokes, Steven R., Tampa 192-3
Nuss, Robert C., Jacksonville 188-3; 451-6
Orr, Mrs. Rex (Betty), St. Petersburg 645-8
Ortiz, Joseph E., Titusville 185-3
Orton, Dale 224-3

Patrowicz, Tully C., Tampa 390-5
Pedrero Jr., Edward, Tampa 835-11
Pennington, George P., Lake City 686-9
Perez, Luis M., Sanford 9-1; 93-2; 169-3; 257-4; 363-5; 437-6; 505-7; 585-8; 667-9;
Perry, James B., Ft. Lauderdale 643-8; 741-10; 827-11; 911-12
Pitchenik, Arthur E., Miami 107-2
Primich, Frank J., The Meadowlands, NJ 132-2
Prockop, Leon D., Tampa 691-9
Rechtine, Glenn R., Tampa 192-3
Redderson, Mrs. Carl (Tommy Jean), St. Petersburg 559-7
Reese, Charley, Orlando 339-4
Register, John Michael, Tampa 701-9
Register, Loretta J., Tampa 636-8
Reiser, Stanley 54-1
Restak, Richard, Washington, D.C. 476-6
Rich, Spencer, Washington, D.C. 411-5
Roberts, H.J., West Palm Beach 342-4
Robinson, Walker L., Maryland 35-1
Roehrig, C. Burns, Boston, MA 637-8
Rojas, Joseph E., Titusville 185-3
Rosenfeld, Evan, Cambridge, MA 847-11
Rubin, Robert, Miami 880-11
Sadler, L. Anne, Gainesville 849-11
Saeed, Muhammad, Palatka 381-5
Salomon, Daniel R., Gainesville 849-11
Sandroni, Stephen, Jacksonville 384-5
Schiedmayer, David L., Milwaukee, WI 132-2

Schiff, Eugene R., Miami 107-2
Scott, Meredith, Orlando 114-2
Scott Jr., Thomas E., Daytona Beach 123-2
Seymore, Mrs. James (Rita), Ocala 483-6
Shephard, Bruce D., Tampa 759-10; 763-10
Sherman, James M., Tampa 454-6
Silbiger, Martin L., Tampa 192-3
Singleton, George T., Gainesville 377-5
Sloane, R. Bruce, Los Angeles, CA 882-11
Smith, Allen O., St. Petersburg 691-9
Solomon, Daniel R., Gainesville 111-2
Sodeman Jr., William A., Tampa 131-2, 474-6
Spira, Thomas J., Atlanta, GA 107-2
Straight, William M., Coral Gables 289-4
Szentivanyi, Andor, Tampa 796-10
Taylor, Chickweed, Tallahassee 1041-12
Temple, J. Donald, Miami 847-11
Temple, Donald F., Tampa 526-7
Tignor, Mrs. Milton R. (Jo), North Palm Beach 717-9
Vijayanagar, R.R., Tampa 447-6
Wiktor, Tadeusz J., Philadelphia, PA 517-7
Willard III, Edgar H., Winter Haven 447-6
Williams, J. Kell, Tampa 769-10
Wolfe, Leon J., Miami 701-9
Yelverton, Robert W., Tampa 777-10
Zuckerman, Mortimer B. 223-3

Saturday, February 7, 1987

Gastroenterology Update

Gastrointestinal Diseases of the Elderly, co-sponsored by:
University of Miami School of Medicine
Mount Sinai Medical Center of Greater Miami

held at Mount Sinai Medical Center in Wolfson Auditorium
Course Co-Directors: Jamie S. Barkin, M.D., and Arvey I. Rogers, M.D.

Approved for Category I credits 7.5 AMA and AAFP Nursing Contact Hours 7.5

Registration Fees: Physicians — $65; Nurses — $35

Guest Faculty: L.J. Brandt, M.D.; Peter B. Cotton, M.D.; John Galambos, M.D.; Thomas R. Hendrix, M.D.; Peter R. Holt, M.D.; Dennis M. Jensen, M.D.

For information contact Department of CME, Mount Sinai: (305) 674-2311, 4300 Alton Road, Miami Beach, Florida 33140.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility: The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are NOT simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal.*

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

ADVERTISERS

Alan Grieco, Ph.D.
Service 1042

AT&T
Service 909

Brown Pharmaceutical
Android 903
Lipo-Nicin 1047

Daniels Pharmaceuticals, Inc.
Levoxine 904

Eli Lilly & Company
Ceclor 1036

Fair Oaks Hospital
Service 914

First Defense Legal Services Insurance Corp
Service 913

FMA Sponsored Insurance Plans
Service 926

Florida Physicians' Insurance Company
Service 902

Glaxo/Roche
Zantac 902c

Gironde Bros., Inc.
L'Humiditemp 1049

GTE Telenet
Service 1029

Gulf Coast Diversified, Inc.
Service 925

Health Cap
Service 920

Knoll Pharmaceutical Company
Vicodin 1042a

Marion Laboratories, Inc.
Cardizem 1042c

Mount Sinai Medical Center
Meeting 1049,1057

Roche Products, Inc.
Dalmane 1059

Smith, Kline and French Company
Dyazide 902b

University of Florida
Recruitment 903

University of Miami
Seminar 910,1030,1042,1057

University of South Florida
Seminar 1048

Upjohn Company
Motrin 902a

Willingway Hospital
Service 1042

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Vice President

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D., Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®

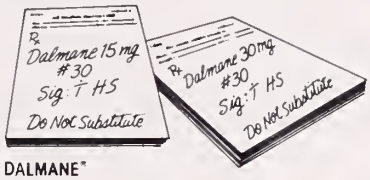
brand of
flurazepam HCl/Roche ℞

sleep that satisfies

15-mg/30-mg
capsules



References: 1. Kales J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. **2.** Koles A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al. Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp 25-31, Oct 1978. **7.** Koles A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al*: Symposium on the Treatment of Sleep Disorders, Telecanference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
brand of
flurazepam HCl/Roche ℞

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see adjacent page for references and summary of product information.

DALMANE®

brand of
flurazepam HCl/Roche ℞

sleep that satisfies



ROCHE®

Copyright © 1986 by Roche Products Inc. All rights reserved.